**FORM 2A:**
PERIOPERATIVE MEDICAL INFORMATION
(Filled in by surgeon at the same time as the operation description and may be supplemented by discharge or by reporting)

# Registration form for patients undergoing degenerative cervical surgery

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0510 – Version 1

Date of surgery ☐☐ Day ☐☐ Month ☐☐ Year

Date of completion ☐☐ Day ☐☐ Month ☐☐ Year

## Patient data (barcode)

Name

National identity number ☐☐☐☐☐☐ ☐☐☐☐☐

## Medical history (check all that apply)

Previously neck operated?

☐ Yes, same level ☐ Yes, different level ☐ No

The patient has been operated ☐☐ times in the cervical spine

Other relevant diseases, injuries or ailments

☐ No

Yes, please specify

| | |
|---|---|
| ☐ Rheumatoid arthritis | ☐ Migraine |
| ☐ Ankylosing spondylitis | ☐ Cerebrovascular disease |
| ☐ Other rheumatic disease | ☐ Chronic neurological disease |
| ☐ Undergoing immunotherapy | ☐ Hypertension |
| ☐ Chronic musculoskeletal pain | ☐ Cardiovascular disease |
| ☐ Carpal tunnel syndrome | ☐ Vascular claudication |
| ☐ Shoulder arthrosis (osteoarthritis)/ impingement | ☐ Cancer |
| ☐ Whiplash / neck injury | ☐ Asthma /chronic obstructive pulmonary disease (COPD) |
| ☐ Osteoporosis | ☐ Diabetes mellitus |
| ☐ Depression / anxiety | ☐ Other endocrine disorders |

Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Radiological assessment (check all that apply)

1. Examination

| | |
|---|---|
| ☐ CT | ☐ Nerve root block |
| ☐ MRI | ☐ Cervical spine X-ray |
| ☐ Myelography | ☐ With flexion/extension |
| ☐ EMG/Neurography | |

2. Findings

| | |
|---|---|
| ☐ Normal | ☐ Root canal stenosis |
| ☐ Disc herniation | ☐ Spondylolisthesis |
| ☐ Cervical spinal stenosis | ☐ Intramedullary signal changes on MRI |
| ☐ Degenerative changes on multiple levels than operated | |

☐ Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Surgical indication(s) (check all that apply)

☐ Pain: ☐ Neck ☐ Arm

☐ Paresis, Grade (0-5): _ _ _

☐ Myelopathy: ☐ Sensory ☐ Motor

☐ Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Etiology if reoperated within 90 days (check only one box)

| | |
|---|---|
| ☐ Cerebrospinal fluid leak | ☐ Loosening/misplacement of osteosynthesis material |
| ☐ Deep wound infection | ☐ Misplacement of implant |
| ☐ Superficial wound infection | ☐ Wrong level surgery |
| ☐ Hematoma | ☐ Inadequate decompression |
| ☐ Postoperative spondylolisthesis | |

☐ Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Operation category (check only one box)

☐ Elective ☐ Emergency ☐ Urgent

Day surgery (no overnight stay in hospital)

☐ Yes ☐ No

## ASA-classification (check only one box)

☐ I No organic, physiological, biochemical or mental disorders

☐ II Moderate illness or disorder

☐ III Serious illness or disorder

☐ IV Life-threatening organic disease

☐ V Dying patient

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## Ranawat classification for myelopathy (check only one box)

- ☐ I — No neurological deficit
- ☐ II — Subjective weakness, hyperreflexia, and dysesthesia
- ☐ III — Objective weakness and long tract signs
  - ☐ A — Ambulatory
  - ☐ B — Quadriparesis and non-ambulatory

## Operation method (check all that apply)

Approach

☐ Posterior — Anterior: ☐ Right side ☐ Left side

Did the surgeon use visual enhancement device?

☐ Microscopy ☐ Surgical loupes ☐ Endocopy ☐ No

Anterior cervical discectomy and fusion or arthroplasty

☐ Discectomy — ☐ Bone block ☐ Plate ☐ Cage ☐ Disc arthroplasty

Surgical decompression

☐ Posterior foraminotomy — ☐ Unilateral ☐ Bilateral

Other posterior decompression

☐ Lamin-ectomy ☐ Laminoplasty ☐ Skip lamin-ectomy ☐ Hemilamin-ectomy

☐ Corpectomy — ☐ Plate ☐ Cage ☐ Bone block

Other surgical methods (check only one box)

☐ Revision of osteosynthesis material ☐ Revision of cage

☐ Removal of osteosynthesis material ☐ Revision of disc prosthesis

Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Posterior fusion (check all that apply)

☐ Cervical ☐ Occipitocervical

Instrumentation ☐ Wire ☐ Screws ☐ Rod

Proximal level, e.g. C0 ☐☐ Distal level, e.g. TH1 ☐☐☐

## Type of bone graft (check all that apply)

☐ Autograft ☐ Bone substitute ☐ Bone bank

## Decompressed level and side (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ C0/C1 | ☐ Right | ☐ Left | ☐ C4/C5 | ☐ Right | ☐ Left |
| ☐ C1/C2 | ☐ Right | ☐ Left | ☐ C5/C6 | ☐ Right | ☐ Left |
| ☐ C2/C3 | ☐ Right | ☐ Left | ☐ C6/C7 | ☐ Right | ☐ Left |
| ☐ C3/C4 | ☐ Right | ☐ Left | ☐ C7/TH1 | ☐ Right | ☐ Left |

Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## Antibiotic prophylaxis

☐ No ☐ Yes, specify;

Medication:......................Dosage:........... Amount:...........

Example: Keflin 2g x1

☐ Operation day only

☐ Or specify number of days ...........

## Wound drainage

☐ Yes ☐ No

## Knife time (skin to skin), state time of day

Operation start ☐☐ ☐☐ (hour/ minutes) Operation end ☐☐ ☐☐ (hour/ minutes)

## Peroperative complications (check all that apply)

| | |
|---|---|
| ☐ Dural tear | ☐ Anaphylactic reaction |
| ☐ Nerve root injury | ☐ Medulla injury |
| ☐ Wrong level/side surgery | ☐ Esophageal injury |
| ☐ Misplacement of implant | ☐ Large blood vessel injury |
| ☐ Perioperative transfusion due to bleeding | ☐ Cardiovascular complications |
| ☐ Respiratory complications | ☐ Other nerve injury |

☐ Other, please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

## State maximum two operation codes that best describe the procedure (NCSP):

☐☐☐ ☐☐ ☐☐☐ ☐☐

## To be filled in at the end of hospital stay/discharge

## Date of discharge and length of hospital stay

Date of discharge ☐☐ ☐☐ ☐☐ (Day Month Year) ☐☐☐ (total number of days)

## In case of death during the hospital stay, state the cause

Please specify _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _