Patient Registration Form :

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Master ☐ Other: _____

Given Names: _____ **Surname:** _____

Date of Birth: _____

Phone: (H) _____ **(W)** _____ **(M)** _____

Email:_____

Street Address:_____

Suburb:_____**Post Code:** _____

Postal/Billing Address (If Different): _____

Parents Name(if child) _____

Next of Kin: _____**Phone:** _____**Relationship**: _____

Fees paid by: ☐ **SELF** ☐ **WORKERS COMP** ☐ **OTHER:** _____

Family Doctor: _____

Address: _____

Referring Doctor: _____

Address: _____

Physiotherapist or Physio Clinic: _____

Address: _____

Patient Occupation: _____

Private Health Fund: _____ **Number**_____**Ref**_____

Medicare No: _ _ _ _ _ _ _ _ _ _ _ **Ref Number:**_____**Exp:** _____

Medicare Accnt Holder (if patient is child): Name _____ **DOB:**_____

Dept Veteran Affairs No: _____ **Exp:** _____

Has another Orthopaedic opinion been sought? ☐ YES ☐ NO

Permission to Collect and Store Information:
I have read the above and agree to the collection and storage of information. I authorize Dr/Prof ___**ROE**_____ to release medical information to the Referring Doctor/ Insurance Company/ Solicitor or the other persons nominated by me.

SIGNED: _____ DATE: _____

Knee Injury Assessment Form (Patient to Complete)
Dr Justin Roe

NAME:
DOB:

1. Date of Consultation: _____

2. Which is your affected knee (tick) ☐ **Left** ☐ **Right**

3. How long has your knee been bothering you?_____

4. If applicable, what were you doing when you injured your knee? _____

_____

5. What is the main problem with your knee? _____

_____

_____

_____

5a. Please tick any knee symptoms that have been experienced in the last month:

- ☐ - swelling
- ☐ - grinding
- ☐ - catching
- ☐ - locking
- ☐ - locking joint
- ☐ - stiffness
- ☐ - pain
- ☐ - instability/giving way
- ☐ - difficulty squatting
- ☐ - difficulty upstairs
- ☐ - difficulty downstairs

6. What treatment have you had for your knee injury? _____

_____

6a. Are your symptoms:

- ☐ - improving
- ☐ - worsening
- ☐ - unchanged

7. Have you injured the knee previously, or had surgery to either knee (please describe)? _____

_____

_____

8. What activities do you wish to return to following your treatment? _____

_____

9. What are your expectations from today's consultation with Dr Roe?_____

_____

_____

_____

10. Please enter your height:_____weight:_____

Participant Information Sheet & Consent Form

NORTH SYDNEY ORTHOPAEDIC & SPORTS MEDICINE CENTRE

Study Title	**Database of Hip and Knee Disorders**
Principal Investigators	A/Prof Leo Pinczewski, Dr Michael O'Sullivan, A/Prof Justin Roe, Dr Matt Lyons, Dr Benjamin Gooden, Dr Lucy Salmon
Location	North Sydney Orthopaedic and Sports Medicine Centre, The Mater Clinic, Sydney

Part 1 What does my participation involve?

1 Introduction

You are invited to participate in a database of Hip and Knee disorders which systemically monitors the outcomes of lower limb surgery performed by the investigating surgeons listed above.

2 What is the purpose of this research?

The purpose of this database is to systematically monitor the outcome of lower limb surgery that is performed by the investigating surgeons for the following purposes:

- Quality Assurance: this means systematically monitoring the types of treatment and the results of the treatment that our patients receive. This is to ensure that you and other patients having orthopaedic surgery are receiving the best and most current standard of care.
- Enable identification of people who might be eligible for participation in future clinical research/trials. If further participation is involved from you we will contact you and invite further participation which will be strictly voluntary.

3 What does participation in this research involve?

If you agree to participate in this study, you will be asked to confirm your consent via the online form sent by our staff or by email or post as described in Part 3 below. *Your participation in this study involves the completion of questionnaires regarding your hip or knee symptoms and general health before, and at 6 and 12 months after surgery. These questionnaires may be completed online or using a paper copy via mail. You do NOT need to attend for any assessments or undergo further tests.* Additionally, information relating to your name, demographics and details of the surgical procedure will be added to the database. In addition, the researchers would like to have access to your medical records to obtain relevant information such as your relevant clinical and operative details and contact information relevant to the study. This information is identifiable by your name. This information is only accessible by the surgeons and their research staff.

4 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. If you do decide to take part, you may keep this Participant Information and Consent Form. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with NSOSMC.

5 What are the possible risks and benefits of taking part?

There will be no clear benefit to you from your participation in this research. There are no foreseeable risks associated with participation.

Part 2 How is the research project being conducted?

6 What will happen to information about me?

By signing the consent form you consent to the study doctor and relevant research staff collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. Data is stored on a secure medical server, accessible only by your surgeons and research staff. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. Information about you may be obtained from your health records held at this and other health services for the purpose of this

research. By signing the consent form you agree to the research team accessing health records if they are relevant to your participation in this research project.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. Information about your participation in this research project may be recorded in your health records.

In accordance with relevant Australian and/or New South Wales privacy and other relevant laws, you have the right to request access to the information collected and stored by the research team about you. You also have the right to request that any information with which you disagree be corrected. Please contact the research team member named at the end of this document if you would like to access your information. Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission, or as required by law.

7 Who is organising and funding the research?

This research project is being conducted and funded by the investigating surgeons with the staff support from the Mater Hospital.

8 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of St Vincent's Human Research Ethics Committee. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

9 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any medical problems which may be related to your involvement in the project you can contact the Coordinating Study Investigator, Dr Lucy Salmon on 02 9409 0500, lsalmon@nsosmc.com.au, or your treating surgeon. If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact St Vincent's Hospital HREC on 8382 4960.

Part 3 Please confirm your participation in Database of Lower Limb Disorders

Please confirm your consent to participation in this study. By providing consent you declare

- I have read this Participant Information Sheet or someone has read it to me in a language that I understand.
- I understand the purposes and procedures of the research described in the project.
- I consent to take part in the research & the use of your personal and health information as described.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future health care.
- I understand that I will be given a copy of this document to keep

TO CONSENT VIA EMAIL:

Copy and paste Part 3 above and send to research@nsosmc.com.au with your name

TO CONSENT VIA OUR WEBPAGE

Click on the link sent to you by email by our staff

TO CONSENT VIA POST

Send this page to Dr Lucy Salmon, NSOSMC Suite 2 The Mater Clinic, 3 Gillies St, Wollstonecraft NSW 2065.

Name of Participant (please print) _____

Signature _____ Date _____

Workers Compensation Details:

Date of Injury: _____

Claim Number: _____

Insurance Company: _____

Insurance Company Address: _____

Case Manager: _____

Case Manager Phone No: _____

Case Manager Fax No: _____

Name of Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

I have provided the above information to the best of my knowledge and understand that I will be personally responsible for the payment of all Medical Fees should the cost not be met by my insurer.

NAME: _____ DOB: _____

SIGNED: _____ DATE: _____