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 back surgery

NORspine

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Version 3

Patient date (Barcode)

Name

National identity number ☐☐☐☐☐☐ ☐☐☐☐☐

Admission date ☐☐ ☐☐ ☐☐

Date of surgery ☐☐ ☐☐ ☐☐

day month year

Main surgeon (experience)

Do you work as a spine surgeon on a daily basis?

☐ Yes ☐ No

For how many years have you been practicing spinal surgery regularly

☐ <1 year ☐☐ More than one year (please specify how many years)

Did you have an assistant during the operation? ☐ No

☐ Yes, more experienced ☐ Yes, equally experienced ☐ Yes, less experienced

Previous lumbar spine surgery

Has the patient previously had lumbar spine surgery? (check all that apply)

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

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

Which of the following best describes the most recent procedure

☐ Prolapse surgery
☐ Disc prosthesis
☐ Microdecompression for spinal stenosis
☐ Fusion surgery
☐ Laminectomy for spinal stenosis
☐ Removal/revision of implants

Use of anticoagulants and antiplatelet or immunosuppressive medication

Does the patient use such medication on a daily basis?

☐ No ☐ Yes If yes, which one _____

If applicable, specify the date of discontinuation ☐☐ ☐☐ ☐☐

day month year

Was postoperative thromboprophylaxis medication given?

☐ No ☐ Yes If yes, please specify _____ First dose given preoperatively ☐

☐ Steroids ☐ Other immunosuppressive treatment

Other relevant diseases, injuries or problems (check all that apply)

☐ No

Yes, please specify:

☐ Rheumatoid arthritis
☐ Ankylosing spondylitis
☐ Other rheumatic disease
☐ Hip- or knee arthrosis
☐ Depression / anxiety
☐ Generalised pain syndrome
☐ Chronic neurological disease
☐ Cerebrovascular disease
☐ Cardiovascular disease
☐ Polyneuropathy
☐ Vascular claudication
☐ Chronic pulmonary disease
☐ Cancer
☐ Osteoporosis
☐ Osteoporotic thoracolumbar fracture
☐ Hypertension
☐ Diabetes mellitus
☐ Other endocrine disorders
☐ Prostatism

Other, please specify _

Radiological assessment (check all that apply)

1. Examination

☐ CT ☐ With flexion/extension
☐ MRI .....mm of translation
☐ Lumbosacral spine x-ray .....° of angulation
☐ Diagnostic blockade ☐ Facet Joint ☐ Nerve Root

2. Findings

☐ Prolapse
☐ Intraforaminal prolapse
☐ Extreme lateral/extraforaminal prolapse
☐ Central spinal stenosis
☐ Lateral/recess stenosis
☐ Foraminal stenosis
☐ Only disc degeneration / spondylosis without nerve affection
☐ Isthmisc spondylolysis
☐ Isthmisc spondylolistesis
Meyerding grade .....(I-IV)
☐ Degenerative spondylolisthesis (on MRI) ....mm of displacement
☐ Degenerative scoliosis
☐ Kyphosis
☐ Synovial cyst

Does the patient have Modic changes? ☐ Yes ☐ No

☐ Modic type I ☐ Same level ☐ Different level
☐ Modic type II ☐ Same level ☐ Different level

Is the patient operated for scoliosis/kyphosis?(check all that apply)

☐ Yes ☐ No

Cobb angel of .....° Pelvic tilt (PT) of .....°

Sagittal vertical axis (SVA).....cm Sacral slope (SS) of .....°

Pelvic incidence (PI) of .....° Lumbar lordosis (LL) of .....°

Neurological symptoms and findings

☐ Paresis, grade (0-5): .....

Duration (check only one box)

☐ Less than 24 hours, or specify number of hours .....
☐ Less than one week, or specify number of days .....
☐ 1 week to 3 months, or specify number of weeks .....
☐ More than 3 months

☐ Cauda equina syndrome

Duration (check only one box)

☐ Less than 24 hours, or specify number of hours .....
☐ Less than one week, or specify number of days .....
☐ 1 week to 3 months, or specify number of weeks .....
☐ More than 3 months

Positive Lasegue test (less than 60°) ☐ Yes ☐ No

Flexion relief ☐ Yes ☐ No

Operation category

☐ Elective ☐ Emergency ☐ Urgent

(handled faster than ordinary waiting time, but not emergency surgery)

Day surgery (no overnight hospital stay)

☐ Yes ☐ No

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Turn the page

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

Operation method (check all that apply)

Was the surgical safety checklist used? (check all that apply)

☐ Yes, at the start ☐ Yes, at the end ☐ No

Did the surgeon use vision enhancement?

☐ No ☐ Microscope ☐ Surgical loupes ☐ Endoscope

Was a computer navigation used?

☐ Yes ☐ No

Removal of prolapse?

- ☐ No
- ☐ Yes, with emptying of the disc (discectomy)
- ☐ Yes, without emptying the disc

Surgical decompression

☐ Decompression with preservation of midline structures
- ☐ Unilateral
- ☐ Bilateral with unilateral approach
- ☐ Bilateral with bilateral approach

- ☐ Spinous process osteotomy
- ☐ Laminectomy

Other surgical methods

- ☐ Percutaneous fusion surgery
- ☐ Disc prosthesis
- ☐ Fusion for axial back pain without radiating pain (no decompression)
- ☐ Revision of osteosynthesis material
- ☐ Removal of osteosynthesis material
- ☐ Pedicle Subtraction Osteotomy (PSO)
- ☐ Interpedicular osteotomy (Ponte/Smith-Petersen)

Other, please specify _

Surgical approach (check only one box)

- ☐ Midline
- ☐ Anterior
- ☐ Lateral (Wiltze)
- ☐ Extraforaminal access via midline

Levels of decompression (check all that apply)

☐ Th12/L1 ☐ L1/L2 ☐ L2/L3 ☐ L3/L4

☐ L4/L5 ☐ L5/S1 ☐ Other, please specify_____

Number of levels decompressed_____

Fusion surgery (instrumented/ non-instrumented)

☐ Yes ☐ No If yes:

☐ Posterolateral fusion
- ☐ Instrumented
- ☐ Non-instrumented

- ☐ Anterior lumbar interbody fusion (ALIF)
- ☐ Transforaminal lumbar interbody fusion (TLIF)
- ☐ Posterior lumbar interbody fusion (PLIF)
- ☐ Extreme lateral interbody fusion (XLIF)

Type of bone graft (check all that apply)

☐ Autograft
- ☐ Local bone
- ☐ From iliac crest

- ☐ Bone graft substitutes
- ☐ Bone bank

Fused levels

Upper level, e.g. Th11 ☐☐ Lower level, e.g. S1 ☐☐

Number of fusion level(s):_____

Iliac screws used? ☐ Yes ☐ No

If yes: ☐ Unilateral ☐ Bilateral

Cemented skrews

Cement augmentation used? ☐ Yes ☐ No

Antibiotic prophylaxis

☐ No ☐ Yes, please specify

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

Example: Cephalotin 2g x1

- ☐ Only the day of surgery
- ☐ If applicable, please specify number of days .....

Wound drainage

☐ Yes ☐ No

Knife time (skin to skin)

Surgery start ☐☐ ☐☐ (hours/minutes)

Surgery end ☐☐ ☐☐ (hours/minutes)

Alternatively, total knife time ☐☐ ☐☐ (hours/minutes)

Perioperative complications (calculated automatically)

- ☐ Dural rift
- ☐ Nerve root tear
- ☐ Operated on wrong level/side
- ☐ Misplaced implant
- ☐ Bleeding requiring transfusion
- ☐ Respiratory complications
- ☐ Cardiovascular complications
- ☐ Anaphylactic reaction
- ☐ Other, please specify _____

Enter up to two operation codes that best describe the procedure (NCSP)

☐☐☐ ☐☐ ☐☐☐ ☐☐

To be completed at discharge

Discharge date ☐☐ ☐☐ ☐☐

day month year

Outcome of complications during admission

- ☐ Death
- ☐ Reoperated during the current admission