



SIGN
FRACTURE CARE
INTERNATIONAL

Data Collection Sheets
For Data Entry Into The SIGN Online Surgical Database
www.signsurgery.org

| | | | |
|---|----------------|--------------------------------|--|
| PATIENT CASE INFORMATION: (All fields are required unless otherwise noted.) | | | |
| Hospital Name: | | Case Number: (optional) | |
| Patient Name: | | | |
| Age: | Gender: | Injury Date: | |
| Pediatric Patient Weight (kg): <i>(Applicable only for Pediatric Fin Nail treatment – see Fracture Page)</i> | | | |
| Optional Patient Contact Information: <i>(This information will be available only to the applicable hospital).</i> | | | |
| Address: | | | |
| Phone Number: | | Email Address: | |

SURGERY INFORMATION: Copy this page for each additional surgery for this patient.

Surgery Date (month/day/year):

Surgeon Name(s):

1. Antibiotics Used? Yes No Unknown

If yes:

How long from time of injury? _____ hours _____ days

Name of Antibiotic: _____

Duration of Antibiotic Coverage: _____ hours _____ days

2. Surgery Comments:

FRACTURE INFORMATION: (Copy for each additional fracture.)

Patient Name:

Case Number:

1. Fracture Side: Left Right

2. Surgical Approach: Antegrade Femur Tibia
 Antegrade Humerus Hip Fracture
 Retrograde Femur

3. Location of Fracture: Proximal Middle Distal Segmental
(check all that apply) Femoral Neck Intertrochanteric Subtrochanteric

4. Type of Fracture: Closed Gustilo IIIa
 Gustilo I Gustilo IIIb
 Gustilo II Gustilo IIIc

5. Stability of Fracture: (Hip Fracture Only)
(check all that apply) Stable Unstable Lateral Femur Wall
 Unstable Posterior Medial Fragment

6. Time from injury to Debridement: ___ hours ___ days

7. Time from injury to Skin Closure: ___ days

8. Method of Wound Closure:
(check all that apply) Primary Skin Graft Muscle Flap
 Secondary Other: _____

9. Nonunion: Yes No

10. Previous Implant Used: Yes No
If Yes, check all that apply: External Fixation Plate
 IM Nail Wire
If External Fixation: 1. How long was external fixation in place? ___ days
 2. Time between removal of ext. fixation and SIGN? ___ days

11. Method of Reaming: None Hand Power

12. Fracture Reduction: Open Closed

13. Comments:

FRACTURE INFORMATION (continued from previous page.)

Patient Name:

Case Number:

14. Nail Type Used: (Please mark the type of nail used to treat this fracture.)

| Standard Nails | 200 | 220 | 240 | 260 | 280 | 300 | 320 | 340 | 360 | 380 | 400 | 420 |
|----------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| | mm | mm | mm | mm | mm | mm | mm | mm | mm | mm | mm | mm |
| 8 mm | | | | | | | | | | | | |
| 9 mm | | | | | | | | | | | | |
| 10 mm | | | | | | | | | | | | |
| 11 mm | | | | | | | | | | | | |
| 12 mm | | | | | | | | | | | | |

| Standard Fin Nails | 160 | 190 | 240 | 280 | 320 |
|--------------------|-----|-----|-----|-----|-----|
| | mm | mm | mm | mm | mm |
| 7 mm | | | | | |
| 8 mm | | | | | |
| 9 mm | | | | | |
| 10 mm | | | | | |
| 11 mm | | | | | |
| 12 mm | | | | | |

| Pediatric Fin Nails | 140 | 170 | 200 | 240 |
|---------------------|-----|-----|-----|-----|
| | mm | mm | mm | mm |
| 6 mm | | | | |
| 7 mm | | | | |
| 8 mm | | | | |

(You will be prompted for patient weight)

| Standard Hip Nail | 280 |
|-------------------|-----|
| | mm |
| 10 mm | |

| Fin Hip Nail | 240 |
|--------------|-----|
| | mm |
| 10 mm | |

15. Screw Quantities Used: (Please enter the quantity of each type of screw used with this nail.)

| | Standard Interlocking Screws | | | | | | | | | | |
|--------------|------------------------------|----|----|----|----|----|----|----|----|----|----|
| | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 |
| Length in mm | | | | | | | | | | | |
| #Proximal | | | | | | | | | | | |
| #Distal | | | | | | | | | | | |



| Compression Screws (maximum of 2 screws) | | | | | | | | | |
|--|----|----|----|----|----|-----|-----|-----|-----|
| Length in mm | 70 | 80 | 85 | 90 | 95 | 100 | 105 | 110 | 115 |
| Qty | | | | | | | | | |

| SHC Proximal Interlocking Screws (maximum of 1) | | | | | | | | |
|---|----|----|----|----|----|----|----|----|
| Length in mm | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 |
| Qty | | | | | | | | |

| SHC Cortical Screws (max of 1) | | | | |
|--------------------------------|----|----|----|----|
| Length in mm | 30 | 35 | 40 | 45 |
| Qty | | | | |

16. SHC Components Used

- Rod Plate Yes No
- Rod Connector Yes No
- Unicortical Screw Yes No
- 3 Hole Plate Yes No

17. High Visibility (HV) Plates

- HV 2 Hole Yes No
- HV 3 Hole Yes No
- HV 4 Hole Yes No

FRACTURE INFORMATION (continued from previous page.)**Patient Name:****Case Number:****18. X-Rays Taken:** (Please list the names of the digital image files for all x-rays of this fracture.)

| Digital Image X-Ray File Name(s) | Pre-Op | Post-Op | Date Taken |
|----------------------------------|--------------------------|--------------------------|------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | |

Notes on uploading digital image x-ray files:

1. This table is provided for you to keep track of digital x-ray images so that the process of uploading these images to the online database goes smoothly.
2. The time required to upload image files is determined by the size of your digital image files and your internet connection speed.
3. **VERY IMPORTANT:** You can reduce the size of your digital image files by converting them to grayscale (remove all color) and by reducing the dimensions of your pictures to approximately 640 x 480 pixels. Many digital cameras come with software programs capable of these tasks.

FOLLOW-UP INFORMATION: (Copy this sheet for each additional follow-up.)

Patient Name:

Case Number:

Date (month/day/year):

If multiple fractures, which fracture is this a follow-up for?

1. Infection: Yes No

If yes:

Incision of the wound:

Yes

No

Infection depth:

Superficial

Deep (patient returns to surgery)

Duration of infection: _____ weeks

Osteomyelitis

Amputation

2. Partial weight bearing:

Yes

No

3. Painless full weight bearing:

Yes

No

4. Healing by x-ray:

Yes

No

5. Knee flexion greater than 90

degrees: (Not applicable for Hip Fracture)

Yes

No

6. Screw breakage:

Yes

No

7. Screw loosening:

Yes

No

8. Nail breakage:

Yes

No

9. Nail loosening:

Yes

No

10. Deformity: Yes No (under 10 degrees)

If yes:

Alignment: Over 10 degrees varus

Over 10 degrees valgus

Over 20 degrees varus

Over 20 degrees valgus

Rotation: Over 30 degrees

11. Repeat Surgery: Yes No

If Yes, check all that apply: For Infection For Deformity For Non-union

If For Non-Union, check all that apply: Dynamize Exchange Nail

Iliac Crest Bone Graft

Other: _____

12. Comments:

13. Follow-up Images: (Please list the names of all the digital image files for this follow-up.)

| Digital Image File Name(s) | Follow-up X-Ray | Squat & Smile | Shoulder AER | Date Taken |
|----------------------------|--------------------------|--------------------------|--------------------------|------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |