

NZ FRAGILITY FRACTURE REGISTRY - PATIENT LEVEL AUDIT



Facility Name: _____

Headings in italics // *Heading**

These boxes relate to KPIs of the FLS Clinical Standards. These boxes are required to save a record

PATIENT DEMOGRAPHICS		
First Name	Last Name	<i>National Health Index*</i>
Date of birth (dd/mm/yyyy) _ _ / _ _ / _ _ _ _	Sex <input type="checkbox"/> Male <input type="checkbox"/> Intersex or indeterminate <input type="checkbox"/> Female <input type="checkbox"/> Not stated/inadequately described	<i>NZ Ethnic Status</i> <input type="checkbox"/> New Zealand European <input type="checkbox"/> Māori <input type="checkbox"/> Cook Island Māori <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Not elsewhere included <input type="checkbox"/> Other
Contact Phone Number	Post Code	
Email		
Opt out <input type="checkbox"/>	Non Contactable <input type="checkbox"/>	Declined FLS <input type="checkbox"/>

IDENTIFICATION		
<i>Index Fracture Date*</i> _ _ / _ _ / _ _ _ _	<i>Index Type of Fracture</i> <input type="checkbox"/> Fragility <input type="checkbox"/> Atypical	<i>Admission to Hospital</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already an inpatient <input type="checkbox"/> Not known
<i>Fracture Sites (1 = index fracture. Mark as numbers, up to 3 fractures)</i> //		
<input type="checkbox"/> Wrist <input type="checkbox"/> Proximal humerus <input type="checkbox"/> Hip <input type="checkbox"/> Thoraco-lumbar spine	<input type="checkbox"/> Sacrum and pelvis <input type="checkbox"/> Other humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm other than wrist	<input type="checkbox"/> Sternum, ribs, clavicle, and scapula <input type="checkbox"/> Other femur including supracondylar knee <input type="checkbox"/> Tibial plateau and patella <input type="checkbox"/> Other lower leg and ankle
<i>Pre-fracture Residence</i> <input type="checkbox"/> Private residence (including unit in retirement village) <input type="checkbox"/> Residential aged care facility <input type="checkbox"/> Other <input type="checkbox"/> Not known	<i>Pre-fracture Mobility</i> <input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with either a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair / bed bound <input type="checkbox"/> Not known	<i>Pre-fracture Cognitive Status</i> <input type="checkbox"/> Normal cognition <input type="checkbox"/> Impaired cognition or known dementia <input type="checkbox"/> Not known
<i>Method of Identification</i> <input type="checkbox"/> Emergency Department trauma list <input type="checkbox"/> Inpatient diagnosis list (filtered for fracture) <input type="checkbox"/> Fracture clinic list <input type="checkbox"/> Internal hospital referral <input type="checkbox"/> GP referral <input type="checkbox"/> External FLS to FLS <input type="checkbox"/> Out of area referral		<i>Appropriate for Further Assessment</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ACC fracture claims <input type="checkbox"/> Discharge coding <input type="checkbox"/> Radiology reports for any fracture <input type="checkbox"/> Radiology other <input type="checkbox"/> Radiology reports for vertebral fractures ("wedge, compression etc")		<i>Reason Not Appropriate for Further Assessment</i> <input type="checkbox"/> Deceased <input type="checkbox"/> Terminal illness / palliative care <input type="checkbox"/> Frail - life expectancy of less than a year / advanced dementia <input type="checkbox"/> End stage renal failure <input type="checkbox"/> Advanced malignancy # not due to metastasis <input type="checkbox"/> Usual residence not in New Zealand or Australia <input type="checkbox"/> Other <input type="checkbox"/> Under care of other specialist service Date of decision _ _ / _ _ / _ _ _ _

NOTES

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INVESTIGATION - BONE HEALTH ASSESSMENT

Bone Health Assessment Date //		Reported Previous Fragility Fractures	Parental history of hip fracture
___/___/_____		<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done
Early Menopause	Current Smoker	Glucocorticoids	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
Rheumatoid Arthritis	Alcohol Use	Previous Significant Osteoporosis Specific Treatment	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
Current Osteoporosis Specific Treatment		Secondary Cause Review	
<input type="checkbox"/> None at time of index fracture <input type="checkbox"/> None: planned "drug holiday" <input type="checkbox"/> Alendronate <input type="checkbox"/> Risedronate <input type="checkbox"/> Etidronate <input type="checkbox"/> Zoledronate <input type="checkbox"/> Denosumab		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Secondary Cause Blood Tests <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not clinically indicated <input type="checkbox"/> Referred to another clinical team (including GP) <input type="checkbox"/> Yes, at least one result reported as abnormal	
Thoraco-Lumbar Imaging		Thoraco-Lumbar Imaging date	Creatinine Clearance (Cockcroft Gault)
<input type="checkbox"/> Fracture identified <input type="checkbox"/> No fracture identified <input type="checkbox"/> No imaging of thoraco-lumbar spine performed or report not available <input type="checkbox"/> Not known		___/___/_____	___ ml/min
Patient Weight	Patient Height	Body Mass Index	
___ kg	___ cm	___ . __	
FRAX Score	Garvan Score		
___ %	___ %		

INVESTIGATION - FALLS RISK ASSESSMENT AND REFERRALS

Falls Risk Assessment Date //	What happened?	
___/___/_____		
2+ Slips, Trips, Falls in Previous 12 months	Potential Cardiac Cause	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Can't remember landing on floor / woke up on floor <input type="checkbox"/> Loss of consciousness / fainted <input type="checkbox"/> Prodromal symptoms associated with postural change (dizziness, light headedness, nausea, diaphoresis, palpitations, chest pain)	
Fear of Falling	<input type="checkbox"/> No symptoms <input type="checkbox"/> Not known <input type="checkbox"/> Not assessed	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known		
Pre-fracture Strength	Strength and Balance Referrals	
Standing from chair without using hands <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Already attending a recognised strength and balance programme <input type="checkbox"/> Already engaged in a self-directed exercise programme <input type="checkbox"/> Referred to a community strength and balance programme <input type="checkbox"/> Referred to an in-home strength and balance programme	
Strength and Balance Referral Date	<input type="checkbox"/> Referred to the "Training for Independence" programme <input type="checkbox"/> No referral made or not appropriate for a strength and balance training programme <input type="checkbox"/> Patient declined Nymbal information provided <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	
___/___/_____		
Referral for Specialist Falls Intervention (Tick all that apply)		
<input type="checkbox"/> No referral made <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Community Occupational Therapist for an in-home safety review		
<input type="checkbox"/> Falls Clinic / Service <input type="checkbox"/> General Practitioner <input type="checkbox"/> Pharmacist review <input type="checkbox"/> Dietician <input type="checkbox"/> General Medicine / Surgery		
<input type="checkbox"/> Orthopaedics <input type="checkbox"/> Rehabilitation in short-term residential care <input type="checkbox"/> ED/Out of hours services <input type="checkbox"/> Other		

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DXA

DXA Ordered or Not //				
<input type="checkbox"/> Ordered <input type="checkbox"/> Declined <input type="checkbox"/> Ordered - did not attend <input type="checkbox"/> Done in last 24 months and not being repeated at this time <input type="checkbox"/> Not appropriate <input type="checkbox"/> Not available				
Previous DXA Date	Previous DXA Spine T-score	Previous DXA Hip T-score	Previous DXA Wrist T-Score	
_ _ / _ _ / _ _ _ _	+ / - . _ _	+ / - . _ _	+ / - . _ . _ _	
Date DXA Ordered	DXA Date //	DXA Spine T-score	DXA Hip T-score	DXA Wrist T-score
_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	+ / - . _ _	+ / - . _ . _ _	+ / - . _ . _ _

INTERVENTION

Osteoporosis Specific Treatment Recommendation		Reason Treatment Not Recommended
<input type="checkbox"/> Not clinically indicated <input type="checkbox"/> Recommended but declined <input type="checkbox"/> Referred to specialist <input type="checkbox"/> Continue current treatment <input type="checkbox"/> Continue current planned drug holiday <input type="checkbox"/> Bisphosphonate therapy (prescribers choice) <input type="checkbox"/> Alendronate <input type="checkbox"/> Risedronate <input type="checkbox"/> Zoledronate		<input type="checkbox"/> Denosumab <input type="checkbox"/> Teriparatide <input type="checkbox"/> Testosterone <input type="checkbox"/> Systemic Oestrogens <input type="checkbox"/> Systemic Oestrogen & Progesterone <input type="checkbox"/> Romosozumab <input type="checkbox"/> Raloxifene <input type="checkbox"/> Not known
<input type="checkbox"/> All assessments indicate treatment not required at present <input type="checkbox"/> Poor renal function <input type="checkbox"/> Poor swallowing, severe GORD, Barrett's oesophagus, achalasia <input type="checkbox"/> Advanced frailty, life expectancy of less than a year <input type="checkbox"/> Long term bisphosphonate treatment, so no further fracture risk benefit. <input type="checkbox"/> Treatment indicated, but no funded alternatives available within Pharmac (NZ) or PBS (Aust) criteria <input type="checkbox"/> Atypical femur fracture <input type="checkbox"/> History of Osteonecrosis of the Jaw or significant active dental disease or planned dental treatment <input type="checkbox"/> No obvious reason <input type="checkbox"/> DNA DXA - No further FLS engagement		
Date of Osteoporosis Treatment Recommendation //	Vitamin D (ARCF)	Long Term Plan //
_ _ / _ _ / _ _ _ _	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
Long Term Plan Date //	Information Package (Tick all that apply) //	
_ _ / _ _ / _ _ _ _	<input type="checkbox"/> Yes - Standard package <input type="checkbox"/> Yes - Know Your Bones <input type="checkbox"/> No <input type="checkbox"/> Not known Date sent _ _ / _ _ / _ _ _ _	

PATIENT NOTES

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16 WEEK FOLLOW UP		
Follow up //	Residence	Mobility
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncontactable <input type="checkbox"/> Declined <input type="checkbox"/> Patient died	<input type="checkbox"/> Private residence (including unit in retirement village) <input type="checkbox"/> Residential aged care facility <input type="checkbox"/> Rehabilitation unit public <input type="checkbox"/> Rehabilitation unit private <input type="checkbox"/> Other hospital / ward / specialty <input type="checkbox"/> Deceased <input type="checkbox"/> Short term care in residential care facility (New Zealand only) <input type="checkbox"/> Other <input type="checkbox"/> Not known	<input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with either a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair / bed bound <input type="checkbox"/> Not relevant <input type="checkbox"/> Not known
Follow up Date //		
__ / __ / ____		
Medication Commenced	Medication //	
<input type="checkbox"/> Yes, same as recommended <input type="checkbox"/> Yes, not same as recommended <input type="checkbox"/> No, not liaised with primary care at this time <input type="checkbox"/> No, now declined <input type="checkbox"/> Not known	<input type="checkbox"/> Recommended but declined <input type="checkbox"/> Awaiting specialist opinion <input type="checkbox"/> Clinical assessment not yet completed <input type="checkbox"/> Alendronate <input type="checkbox"/> Risedronate <input type="checkbox"/> Zoledronate <input type="checkbox"/> Denosumab	<input type="checkbox"/> Teriparatide <input type="checkbox"/> Testosterone <input type="checkbox"/> Systemic Oestrogens <input type="checkbox"/> Systemic Oestrogen & Progesterone <input type="checkbox"/> Romosozumab <input type="checkbox"/> Raloxifene <input type="checkbox"/> Not known
Strength and Balance Started		
<input type="checkbox"/> Yes, same as referred <input type="checkbox"/> Yes, not same as referred <input type="checkbox"/> No, not started yet <input type="checkbox"/> No, now declined <input type="checkbox"/> Not known		

52 WEEK FOLLOW UP		
Follow up //	Residence	Mobility
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncontactable <input type="checkbox"/> Declined <input type="checkbox"/> Patient died	<input type="checkbox"/> Private residence (including unit in retirement village) <input type="checkbox"/> Residential aged care facility <input type="checkbox"/> Other <input type="checkbox"/> Not done <input type="checkbox"/> Not known	<input type="checkbox"/> Usually walks without walking aids <input type="checkbox"/> Usually walks with either a stick or crutch <input type="checkbox"/> Usually walks with two aids or frame (with or without assistance of a person) <input type="checkbox"/> Usually uses a wheelchair / bed bound <input type="checkbox"/> Not done <input type="checkbox"/> Not known
Follow up Date //		
__ / __ / ____		
Further Fragility Fractures	Further Falls	Medication //
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked <input type="checkbox"/> Not known	<input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more <input type="checkbox"/> Not asked <input type="checkbox"/> Not known	<input type="checkbox"/> Never started osteoporosis specific treatment <input type="checkbox"/> No longer taking osteoporosis specific treatment <input type="checkbox"/> Alendronate <input type="checkbox"/> Risedronate <input type="checkbox"/> Zoledronate
Strength and Balance	Reason for no medication	
<input type="checkbox"/> Yes, same as referred <input type="checkbox"/> Yes, not same as referred <input type="checkbox"/> No, now declined <input type="checkbox"/> Not asked <input type="checkbox"/> Not known	<input type="checkbox"/> No longer appropriate (clinician) <input type="checkbox"/> Informed decline (patient) <input type="checkbox"/> Side effects <input type="checkbox"/> Cost to patient <input type="checkbox"/> Nil obvious	<input type="checkbox"/> Denosumab <input type="checkbox"/> Teriparatide <input type="checkbox"/> Testosterone <input type="checkbox"/> Systemic Oestrogens <input type="checkbox"/> Systemic Oestrogen & Progesterone <input type="checkbox"/> Romosozumab <input type="checkbox"/> Raloxifene <input type="checkbox"/> Other <input type="checkbox"/> Not asked <input type="checkbox"/> No medications given - primary care not prescribed <input type="checkbox"/> Not known

PATIENT NOTES