



RACER

Robotic Arthroplasty:
A Clinical and cost Effectiveness
Randomised controlled trial

Trial Number

In-Hospital Pack

This pack contains the instructions, Case report forms and study procedures for the In-hospital stay following TKR. If you have any queries please contact the central study team at:

Racer@warwick.ac.uk

Forms to be completed:

Post-operative Pain Questionnaire *

To be completed by the patient in hospital or over the phone by the Research nurse if the patient is discharged prior to the morning of Day 3 post surgery. Questionnaire MUST be completed for all 3 days where possible.

In-patient Blood loss and Opioid CRF *

* This form can be completed anytime after surgery where the information is readily available. You will need access to pre-operative blood results, post operative blood results, details of transfusion or cell salvage if this was required and access to drug charts detailing opioid use.



**In-Patient Blood loss and
Opioid CRF**

1. Blood

Table 1a) Pre-Surgery Blood Test

(Please use those closest to the patients surgery date)

Name of blood test	Date of Sample	Time Sample was taken	Value/Unit
Haematocrit			
Haemoglobin			

Table 1b) After Surgery Blood Test

(Please use those Closest to the patients discharge date)

Name of blood test	Date of Sample	Time Sample was taken	Value/ Unit
Haematocrit			
Haemoglobin			

2. Transfusion Given

Please tick here if patient did not require a Blood Transfusion

Number of Transfused Units	Date of Blood Transfusion	Time of Blood Transfusion

2a) Cell salvage

Volume of intra-operative or post-operative cell salvage given (ml)

Table 2b) Blood Test taken immediately before a Blood Transfusion

Name of blood test	Date of Sample	Time Sample was taken	Value/Unit
Haematocrit			
Haemoglobin			

Table 2c) Blood Test taken after Blood Transfusion

Name of blood test	Date of Sample	Time Sample was taken	Value/Unit
Haematocrit			
Haemoglobin			

3. Opioid Use in hospital

Please add up the total dose given of each of the following medications, or any other opioid medicine given, up to the end of post-operative day 3 (or discharge, if that is sooner).

Name of Opioid Medicine	Total Dose Day 1	Total Dose Day 2	Total Dose Day 3
Oramorph			
Intravenous Morphine			
Morphine sulphate (MST)			
Oxycodone			
Oxynorm			
Codeine			
Co-codamol 30/500			
Tramadol			
Others: (Please detail and others below)			

4. Date and time of patient discharge from hospital:

Date: - - Time: :

Form completed by (print name):

Signature: **Date signed:**



RACER

Participant Trial Number:

Site Code:

Post-operative Pain Questionnaire

We would like to know about your:

Right knee

Left knee

Please read **ALL** the instructions carefully before completing the questionnaire.

Please use **BLACK** or **BLUE PEN** to complete the questionnaire.

Please **DO NOT** sign or add your name to this questionnaire.

Please **CHECK** that **ALL** the questions have been answered after you finish.

Please **RETURN** the questionnaire in the enclosed envelope

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SECTION A: DAY 1 AFTER SURGERY

Date of completion:

d	d	-	m	o	n	-	y	y	y	y
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Please complete this section on the **FIRST** morning after your operation.

For each question, think about the pain **in your operated knee**.

Please **circle one number** for each question.

1. How much pain do you have in your operated knee right now?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. How bad has your pain been, on average, when your operated knee is at rest, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. How bad has your pain been, on average, when moving your operated knee, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

SECTION B: DAY 2 AFTER SURGERY

Date of completion:

d	d	-	m	o	n	-	y	y	y	y
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Please complete this section on the **SECOND** morning after your operation.

For each question, think about the pain **in your operated knee**.

Please **circle one number** for each question.

1. How much pain do you have in your knee right now?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. How bad has your pain been, on average, when your operated knee is at rest, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. How bad has your pain been, on average, when moving your operated knee, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

SECTION C: DAY 3 AFTER SURGERY

Date of completion:

d	d	-	m	o	n	-	y	y	y	y
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Please complete this section on the **THIRD** morning after your operation.

For each question, think about the pain **in your operated knee**.

Please **circle one number** for each question.

1. How much pain do you have in your knee right now?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

2. How bad has your pain been, on average, when your operated knee is at rest, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

3. How bad has your pain been, on average, when moving your operated knee, over the past 24 hours?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Thank you for completing this questionnaire

