

Sacral Fracture Study

Inclusion / Exclusion Criteria

Surgeon Name Optional = _____

Patient Study ID = _____

Screen Date = _____

Please answer **ALL** of the following inclusion/exclusion questions and retain this form for study records.

Inclusion Criteria

1. Is the patient between the ages of 18 and 80?	YES	No
2. Does the patient have a unilateral sacral fracture?	YES	No
3. Is the patient English speaking?	YES	No
4. Did the patient sign informed consent?	YES	No

If you answered **NO** to any of the above inclusion questions, then the patient is **EXCLUDED**.

Exclusion Criteria

1. Does the patient have an APC injury?	Yes	NO
2. Is the symphysis dislocated?	Yes	NO
3. Does the patient have a Zone 3 sacral fracture?	Yes	NO
4. Is the patient unable to or unwilling to follow-up for 2 years?	Yes	NO
5. Does the patient have a poor propensity to follow up (i.e. drugs, alcohol, etc.)?	Yes	NO
6. Is the patient currently or pending incarceration in prison?	Yes	NO
7. Does the patient have a displaced acetabular fracture?	Yes	NO
8. Was the patient non-ambulatory prior to injury?	Yes	NO

If you answered **YES** to any of the above exclusion questions, then the patient is **EXCLUDED**.

Eligibility: Is the patient eligible for the study based on the above criteria? YES NO

- If yes, please obtain informed consent and complete the pre-op evaluation forms per the requirements of the initial evaluation. **Please have the patient complete the outcome assessment forms (SMFA, VAS) as though it was the day PRIOR TO injury.**
- If no, the patient is not eligible; then STOP. Please retain form for study records.

Sacral Fracture Study

Patient Information Form

Patient Study ID = _____

Today's Date (MM/DD/YY) = _____

Completed By: _____

Directions: Answer every question. If you need to change an answer, completely erase or cross out the incorrect mark, initial, and fill in the correct information.

Last Name	First Name	MI	(For Internal Use Only) Physician's Name:
_____	_____	_____	_____
Street Address 1			Medical Record Number
_____			_____
Street Address 2			

City	State	Zip Code	
_____	_____	_____	
Home Phone (or primary contact) (____)____-____	Work Phone (____)____-____	Date of Birth (MM/DD/YYYY) ____/____/____	
_____	_____	_____	
Sex M/F	E-mail (example: johndoe@abc.com)		
_____	_____		

Alternate Contact Information 1

Relationship to patient	Last Name	First Name	MI
_____	_____	_____	_____
Street Address 1			Home Phone (or primary contact) (____)____-____
_____			_____
Street Address 2			

City	State	Zip Code	
_____	_____	_____	

Alternate Contact Information 2

Relationship to patient	Last Name	First Name	MI
_____	_____	_____	_____
Street Address 1			Home Phone (or primary contact) (____)____-____
_____			_____
Street Address 2			

City	State	Zip Code	
_____	_____	_____	

Patient Study ID = _____

Injury Date (MM/DD/YY) = _____

Completed By: _____

Directions: Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase or cross out the incorrect mark, initial, and fill in the correct information. Mark only one answer for each question unless otherwise instructed.

01a. Date of Injury ___ / ___ / ___ (MM/DD/YY)

b. Time of Injury ___ : ___ AM / PM (circle one)

c. Date of Birth ___ / ___ / ___ (MM/DD/YY)

d. Gender (check one) Male Female

02. Ethnicity

- American Indian
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- White or Caucasian
- Other (*Specify*): _____

03a. Side of sacral fracture

Left Right

04. Additional upper extremity fractures

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Clavicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Scapula	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Humerus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Radius	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Ulna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Wrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

05. Additional lower extremity fractures

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Pelvis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Acetabulum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Femur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Tibia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

06. Additional spinal fractures

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Cervical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Thoracic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lumbar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

07. Additional injuries

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Upper extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Lower extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Spine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

08. Motor function at time of presentation

<u>Location</u>	<u>Normal</u>	<u>Diminished</u>	<u>Absent</u>
a. Ankle dorsiflexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Ankle eversion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Ankle plantarflexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Using the AIS scoring scale, score questions 09-14 (the 6 body regions). Where multiple injuries occur in one region, use the highest scoring injury of that region.

<u>Region</u>	<u>AIS Score</u>
09. Head & Neck	___
10. Face	___
11. Chest	___
12. Abdomen	___
13. Extremity	___
14. External	___

AIS Score
 Minor (AIS 1)
 Moderate (AIS 2)
 Serious (AIS 3)
 Severe (AIS 4)
 Critical (AIS 5)
 Unsurvivable (AIS 6)

15. If known, please record the ISS score below

___ ISS Score

16. Primary cause of injury

- Motor vehicle accident
- Motorcycle accident
- Bicycle accident
- Pedestrian accident
- Recreational activity
- Fall from a height greater than 4 feet
- Fall from a height less than 4 feet
- Direct trauma (blunt)
- Direct trauma (penetrating)
- Crush
- Twist
- Other (*Specify*): _____

Please continue on next page

Patient Study ID = _____

Injury Date (MM/DD/YY) = _____

Completed By: _____

17. High energy injury

- Yes No

18. Work related injury

- Yes No (Skip to question 20)

19. If "Yes", is patient currently seeking or receiving Workers' Compensation?

- Yes No

20. Patient has been or is currently involved in litigation

- Yes No

21. History of smoking or tobacco use

- No (Skip to question 25)
 Yes, quit smoking (Continue to question 22)
 Yes, current smoker (Skip to question 23)

22. If "Yes, quit smoking", specify years tobacco free

_____ years (Skip to question 25)

23. If "Yes, current smoker", specify packs smoked per day

_____ . _____ packs per day

24. If "Yes, current smoker", specify years smoked

_____ years smoked

25. History of drug or alcohol use

- Yes No (Skip to question 28)

26a. If "Yes", is there a history of drug or alcohol abuse?

- Yes (Specify below)
 No (Skip to question 28)

b. If "Yes", specify type of drug or alcohol abuse

- Alcohol Drugs Both

27a. If "History of drug or alcohol abuse", is the patient recovered?

- Yes (Specify below)
 No (Skip to question 28)

b. If "Yes", specify years recovered

_____ years

28a. Patient's height _____ inches

b. Patient's weight _____ lbs

Current Medications (Mark all that apply)

29a. Type	b. Dose	c. Duration
<input type="radio"/> Steroids (examples: Cortone, Deltasone, Medrol, Prelone)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Anticoagulants (examples: Coumadin, Miradon)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Anticonvulsants (examples: Phenytoin, Carbamazepine, Phenobarbital, diazepam)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Statins (examples: Lipitor, Lescol, Pravachol, Zocor)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Anti-inflammatories (examples: Anaprox, Celebrex, Motrin, Naprosyn)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Biophosphonates (examples: Actonel, Boniva, Fosamax)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Antibiotics (examples: Amoxil, Ceporex, Cydomycin, Vibramycin)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Calcium channel blockers (examples: Adalat, Cardizem, Dilacor XR, Norvasc)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Calcium or Vitamin D (examples: Cal-Citrate, Citracal, Os-Cal, Viactiv)	_____ mg/day	___ yrs ___ mos
<input type="radio"/> Parathyroid hormone (examples: Forteo)	_____ mg/day	___ yrs ___ mos

History of surgery

Procedure	Systemic	Extremity	Date (MM/DD/YY)
30. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
31. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
32. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
33. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
34. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
35. _____	<input type="radio"/>	<input type="radio"/>	___/___/___
36. _____	<input type="radio"/>	<input type="radio"/>	___/___/___

Please continue on next page

Patient Study ID = _____

Injury Date (MM/DD/YY) = _____

Completed By: _____

Patient's Current Medical History (Mark all that apply)

In question 37, please indicate the patient's personal medical history of the following conditions.

In question 38, please indicate if the patient is receiving treatment or medication for the condition.

In question 39, please indicate if the condition limits the patient's activities.

	37. <u>History</u>	38. Receiving treatment / <u>Medication</u>	39. <u>Limits activity</u>
Anemia or other blood disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer – metastatic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer – not metastatic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Circulatory disorder including ankle or leg swelling, blood clots, peripheral vascular disease, aneurysm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes – diet controlled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes – medication controlled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes – insulin controlled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leg pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung disease or asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervous system disorder including Parkinson's disease, multiple sclerosis, cerebral palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoarthritis/degenerative arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis/lupus/ankylosing spondylitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcer or stomach disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other history (<i>Specify below</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Study ID = _____

Today's Date (MM/DD/YY) = _____

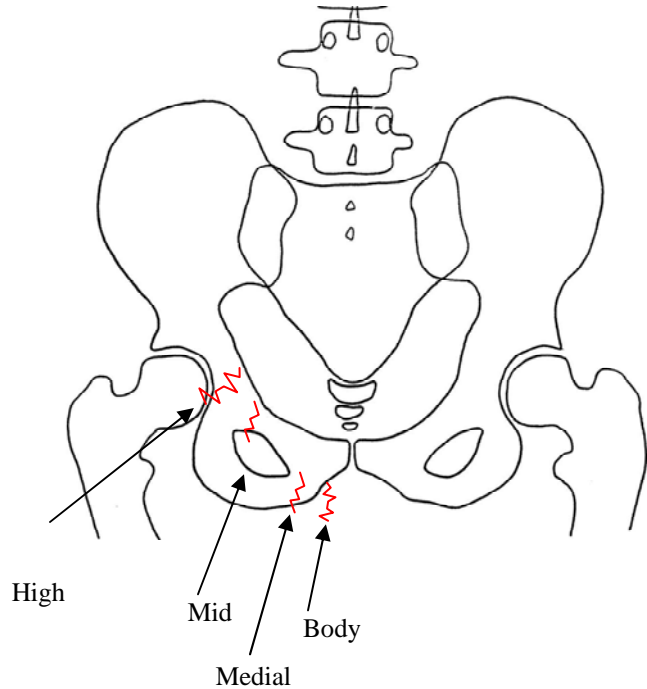
Completed By: _____

01. Mechanism (*check one*)

- LC
- VS
- CMI
- Unknown

02. Anterior (*check all that apply*)

	<u>L</u>	<u>R</u>
High Ramus	<input type="checkbox"/>	<input type="checkbox"/>
Mid Ramus	<input type="checkbox"/>	<input type="checkbox"/>
Medial Ramus	<input type="checkbox"/>	<input type="checkbox"/>
Parasymphseal Body Disruption	<input type="checkbox"/>	<input type="checkbox"/>



03. Posterior

a. Side

- Right
- Left

b. Sacral Fracture (*check one*)

- Zone 1 (ala)
- Zone 2
- Comminuted

c. Other (*check all that apply*)

- Posterior iliac fracture
- Foraminal free fragments

d. Soft Tissue Injury (*check all that apply*)

- Open - Air
- Degloving

Patient Study ID = _____

Today's Date (MM/DD/YY) = _____

Completed By: _____

Radiograph Collection Schedule (Check the appropriate boxes for current visit)

Films	Injury	Post-op	6 wks	3 mo	6 mo	12 mo
AP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outlet	<input type="checkbox"/>	<input type="checkbox"/>	NR	<input type="checkbox"/>	R*	NR
Inlet	<input type="checkbox"/>	<input type="checkbox"/>	NR	<input type="checkbox"/>	R*	NR
CT	<input type="checkbox"/>	Optional \longrightarrow				

NR = Not Required

R* = Required only if change in reduction

Plain films Measurements:

01. AP

- a. Vertical displacement (sacrum) ___ ___ mm
- b. Ischial height difference ___ ___ mm
- c. Injured side ring width ___ ___ mm
- d. Uninjured side ring width ___ ___ mm

02. Outlet

- a. Superior displacement (sacrum) ___ ___ mm
- b. Ischial height difference ___ ___ mm

03. Inlet

- a. Zone (check one) I II III
- b. Posterior displacement (sacrum) ___ ___ mm
- d. Injured width (sacrum) ___ ___ mm
- e. Uninjured width (sacrum) ___ ___ mm

CT scan:

04. S1 level

- a. Zone (check one) I II III
- b. Injured width (sacrum-maximum) ___ ___ mm
- c. Uninjured width ___ ___ mm
- d. Anterior cortex (check one) compressed distracted comminuted non-displaced
- e. Posterior cortex (check one) incomplete complete nondisplaced complete displaced
- f. Translation
 - 1. Displacement: ___ ___ mm
 - 2. A to P sacral depth: ___ ___ mm

05. Quadrilateral level

- a. Angulation injured side from spine ___ ___ ° IR ER
- b. Angulation uninjured side from spine ___ ___ ° IR ER
- c. Quadrilateral surface relative to midline injured side ___ ___ mm
- d. Quadrilateral surface relative to midline uninjured side ___ ___ mm

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____ Completed By: _____

Follow-up Interval: Pre-Injury

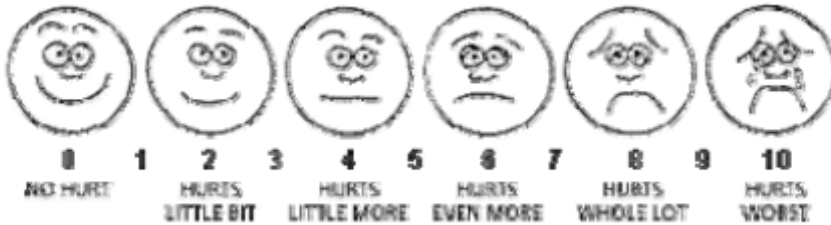
Visual Analog Scale - ANTERIOR

Circle the number at the bottom to indicate your pain level 24hrs before your injury in your anterior (front) side of your pelvis.



Visual Analog Scale - POSTERIOR

Circle the number at the bottom to indicate your pain level 24hrs before your injury in your posterior (back) side of your pelvis.



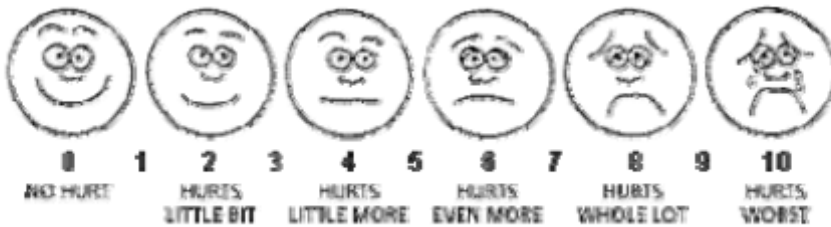
Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____ Completed By: _____

Follow-up Interval: Post-Tx(24hrs) 1 week 3 week 6 week
 3 months 6 months 12 months 24 months

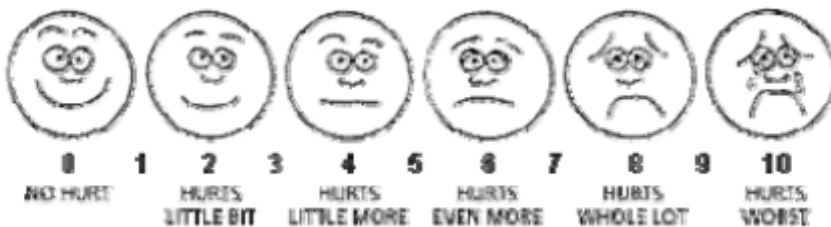
Visual Analog Scale - ANTERIOR

Instructions: Circle the number at the bottom to indicate your pain level over the last day in your anterior (front) side of your pelvis.



Visual Analog Scale - POSTERIOR

Instructions: Circle the number at the bottom to indicate your pain level over the last day in your posterior (back) side of your pelvis.



Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____ Completed By: _____

Follow-up Interval: 6 week 3 month 6 month
 12 month 24 month

01. Motor function at time of presentation

<u>Location</u>	<u>Normal</u>	<u>Diminished</u>	<u>Absent</u>
a. Ankle dorsiflexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Ankle eversion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Ankle plantarflexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

03. Recommended weight bearing

	<u>None</u>	<u>Partial</u>	<u>Full</u>
a. Previous Visit <i>(check one)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Current Visit <i>(check one)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

02. Check all that apply

- Bowel Incontinence
- Bladder Incontinence
- Difficulty Urinating
- Erectile Dysfunction
- Neurologic Pain

04. Ambulatory status at discharge

- TT
- PWB
- FWB

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____ Completed By: _____

Follow-up Interval: Pre-Injury

Majeed Pelvic Score

01. Rate the overall level of pain before your injury:

- Intense, continuous pain, even when at rest
- Intense pain experienced with activity
- Pain is tolerable, but limits activity
- Pain with moderate activity, but free from pain when at rest
- Mild pain that is intermittent that does not interfere with normal activity
- Slight pain that is felt occasionally or no pain at all

02. Work (if patient was not working prior to injury, skip this section)

- No regular work
- Light work
- Change of job
- Same job, reduced performance
- Same job, same performance

03. Level of pain when sitting before your injury

- Painful
- Painful if prolonged or if in awkward position
- Uncomfortable
- Free

04. Level of pain during sexual intercourse before your injury

- Painful
- Painful if prolonged or awkward
- Uncomfortable
- Free

05. Level of pain when standing before your injury

A. Walking aids

- Bedridden or almost
- Wheelchair
- Two crutches
- Two sticks
- One stick
- No sticks

B. Gait (unaided)

- Cannot walk or almost
- Shuffling small steps
- Gross limp
- Moderate limp
- Slight limp
- Normal

C. Walking distance

- Bedridden or few meters
- Very limited time and distance
- Limited with sticks, difficult without prolonged standing possible
- One hour with a stick, limited without
- One hour without sticks, slight pain or limp
- Normal for age and general condition

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____ Completed By: _____

Follow-up Interval: 3 month 6 month 12 month 24 month

Majeed Pelvic Score

01. Rate the overall level of pain:

- Intense, continuous pain, even when at rest
- Intense pain experienced with activity
- Pain is tolerable, but limits activity
- Pain with moderate activity, but free from pain when at rest
- Mild pain that is intermittent that does not interfere with normal activity
- Slight pain that is felt occasionally or no pain at all

02. Work (if patient was not working prior to injury, skip this section)

- No regular work
- Light work
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- Same job, same performance

03. Level of pain when sitting

- Painful
- Painful if prolonged or if in awkward position
- Uncomfortable
- Free

04. Level of pain during sexual intercourse

- Painful
- Painful if prolonged or awkward
- Uncomfortable
- Free

05. Level of pain when standing

A. Walking aids

- Bedridden or almost
- Wheelchair
- Two crutches
- Two sticks
- One stick
- No sticks

B. Gait (unaided)

- Cannot walk or almost
- Shuffling small steps
- Gross limp
- Moderate limp
- Slight limp
- Normal

C. Walking distance

- Bedridden or few meters
- Very limited time and distance
- Limited with sticks, difficult without prolonged standing possible
- One hour with a stick, limited without
- One hour without sticks, slight pain or limp
- Normal for age and general condition

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____

Follow-up Interval: 3 month 6 month 12 month 24 month

SMFA

Directions: We are interested in finding out how you are managing with your injury or arthritis this week. We would like to know about any problems you may be having with your daily activities because of your injury or arthritis. Please answer each question by shading in the circle corresponding to the choice that best describes you. **Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●**

These questions are about how much difficulty you may be having <u>this week</u> with your daily activities because of your sacral injury.						
		Not at all difficult	A little difficult	Moderately difficult	Very difficult	Unable to do
01.	How difficult is it for you to get in or out of a low chair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
02.	How difficult is it for you to open medicine bottles or jars?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
03.	How difficult is it for you to shop for groceries or other things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
04.	How difficult is it for you to climb stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
05.	How difficult is it for you to make a tight fist?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
06.	How difficult is it for you to get in or out of the bathtub or shower?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
07.	How difficult is it for you to get comfortable to sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
08.	How difficult is it for you to bend or kneel down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
09.	How difficult is it for you to use buttons, snaps, hooks, or zippers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	How difficult is it for you to cut your own fingernails?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	How difficult is it for you to dress yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	How difficult is it for you to walk?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	How difficult is it for you to get moving after you have been sitting or lying down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	How difficult is it for you to go out by yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	How difficult is it for you to drive?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	How difficult is it for you to clean yourself after going to the bathroom?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	How difficult is it for you turn knobs or levers, for example, open doors, roll down car windows?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	How difficult is it for you to write or type?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	How difficult is it for you to pivot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	How difficult is it for you to do your usual physical recreational activities, such as bicycling, jogging, or walking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	How difficult is it for you to do your usual leisure activities, such as hobbies, crafts, gardening, card playing, going out with friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	How much difficulty are you having with sexual activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	How difficult is it for you to do <u>light</u> housework <u>or</u> yardwork, such as dusting, washing dishes, or watering plants?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	How difficult is it for you to do <u>heavy</u> housework <u>or</u> yardwork, such as washing floors, vacuuming, or mowing lawns?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	How difficult is it for you to do your usual work, such as a paid job, housework, volunteer activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____

These next questions ask how often you are experiencing problems this week because of your sacral injury.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
26.	How often do you walk with a limp?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	How often do you avoid using your painful limb(s) or back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	How often does your leg lock or give-way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29.	How often do you have problems with concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	How often does doing too much in one day affect what you do the next day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	How often do you act irritable toward those around you, for example, snap at people, give sharp answers, or criticize easily?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	How often are you tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33.	How often do you feel disabled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34.	How often do you feel angry or frustrated that you have this injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next questions are about how much you are bothered by problems you are having this week due to your sacral injury.

		Not bothered at all	A little bothered	Moderately bothered	Very bothered	Extremely bothered
How much are you bothered by:						
35.	Problems using your hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36.	Problems using your back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37.	Problems doing work around your home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38.	Problems with bathing, dressing, toileting or other personal care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39.	Problems with sleep and rest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40.	Problems with leisure or recreational activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41.	Problems with your friends, family or other important people in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42.	Problems with thinking, concentrating or remembering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43.	Problems adjusting or coping with your injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44.	Problems doing your usual work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45.	Problems with feeling dependent on others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46.	Problems with stiffness and pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____

Follow-up Interval: Pre-injury

SMFA

Directions: We are interested in finding out how you were managing before your injury or arthritis. We would like to know about any problems you may have had with your daily activities because of your injury or arthritis. Please answer each question by shading in the circle corresponding to the choice that best describes you. **Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●**

These questions are about how much difficulty you may have had with your daily activities <u>before</u> your sacral injury.		Not at all difficult	A little difficult	Moderately difficult	Very difficult	Unable to do
01.	How difficult is it for you to get in or out of a low chair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
02.	How difficult is it for you to open medicine bottles or jars?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
03.	How difficult is it for you to shop for groceries or other things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
04.	How difficult is it for you to climb stairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
05.	How difficult is it for you to make a tight fist?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
06.	How difficult is it for you to get in or out of the bathtub or shower?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
07.	How difficult is it for you to get comfortable to sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
08.	How difficult is it for you to bend or kneel down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
09.	How difficult is it for you to use buttons, snaps, hooks, or zippers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	How difficult is it for you to cut your own fingernails?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	How difficult is it for you to dress yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	How difficult is it for you to walk?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	How difficult is it for you to get moving after you have been sitting or lying down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	How difficult is it for you to go out by yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	How difficult is it for you to drive?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	How difficult is it for you to clean yourself after going to the bathroom?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	How difficult is it for you turn knobs or levers, for example, open doors, roll down car windows?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	How difficult is it for you to write or type?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	How difficult is it for you to pivot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	How difficult is it for you to do your usual physical recreational activities, such as bicycling, jogging, or walking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	How difficult is it for you to do your usual leisure activities, such as hobbies, crafts, gardening, card playing, going out with friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	How much difficulty are you having with sexual activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	How difficult is it for you to do <u>light</u> housework <u>or</u> yardwork, such as dusting, washing dishes, or watering plants?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	How difficult is it for you to do <u>heavy</u> housework <u>or</u> yardwork, such as washing floors, vacuuming, or mowing lawns?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	How difficult is it for you to do your usual work, such as a paid job, housework, volunteer activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Study ID = _____

Follow Up Visit Date (MM/DD/YY) = _____

These next questions ask how often you experienced problems before your sacral injury.

		<u>None of the time</u>	<u>A little of the time</u>	<u>Some of the time</u>	<u>Most of the time</u>	<u>All of the time</u>
26.	How often do you walk with a limp?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	How often do you avoid using your painful limb(s) or back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	How often does your leg lock or give-way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29.	How often do you have problems with concentration?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	How often does doing too much in one day affect what you do the next day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	How often do you act irritable toward those around you, for example, snap at people, give sharp answers, or criticize easily?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	How often are you tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33.	How often do you feel disabled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34.	How often do you feel angry or frustrated that you have this injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These next questions are about how much you are bothered by problems you had before your sacral injury.

		<u>Not bothered at all</u>	<u>A little bothered</u>	<u>Moderately bothered</u>	<u>Very bothered</u>	<u>Extremely bothered</u>
How much are you bothered by:						
35.	Problems using your hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36.	Problems using your back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37.	Problems doing work around your home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38.	Problems with bathing, dressing, toileting or other personal care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39.	Problems with sleep and rest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40.	Problems with leisure or recreational activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41.	Problems with your friends, family or other important people in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42.	Problems with thinking, concentrating or remembering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43.	Problems adjusting or coping with your injury or arthritis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44.	Problems doing your usual work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45.	Problems with feeling dependent on others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46.	Problems with stiffness and pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Completed By: _____

SACRAL FRACTURES**01. Treatment**

- Non-operative → If yes, form is complete.
- Operative → If yes, complete next section.

Complete questions 01-13 for sacral fractures treated operatively

Patient Positioning and Exposure**01. Patient positioning**

- Supine
- Prone
- Lateral

02. Technique for reduction

- Open (posterior surgical exposure)
- Closed (no surgical exposure for reduction) – *skip to question 4*

03. If “open reduction”, what was the surgical approach?

- Vertical paramedian
- Midline exposure
- Transverse

Reduction

If closed reduction, answer 04.

04. Closed Reduction achieved via

- Patient positioning only (i.e., in situ fixation)
- Supine positioning with weights via distal femoral traction
- Supine positioning with contralateral pelvic stabilization to a fracture table (eg Pro-FX or similar)
- Prone positioning with weights via distal femoral traction
- Prone positioning with contralateral pelvic stabilization to a fracture table (eg Pro-FX or similar)

If open reduction, answer 05.

05. Open Reduction achieved via (mark all that apply)

- Contralateral pelvic stabilization to a fracture table (eg Pro-FX or similar)
- Schantz pin (or similar) placed into the PSIS for manipulation
- Jungbluth clamp (with 3.5 or 4.5)
- Clamp(s) from the ilium to the sacrum
- Clamp(s) from the ilium to the ilium

Please continue on next page

Patient Study ID = _____

Date Completed (MM/DD/YY) = _____

Completed By: _____

06. Fill in the chart below with the implants used

	DIAMETER	LENGTH	THREADS	THREAD SIZE
S1	___ . ___ mm	_____ mm	<input type="radio"/> Full <input type="radio"/> Partial	_____ mm
S1	___ . ___ mm	_____ mm	<input type="radio"/> Full <input type="radio"/> Partial	_____ mm
S1	___ . ___ mm	_____ mm	<input type="radio"/> Full <input type="radio"/> Partial	_____ mm
S2	___ . ___ mm	_____ mm	<input type="radio"/> Full <input type="radio"/> Partial	_____ mm
S2	___ . ___ mm	_____ mm	<input type="radio"/> Full <input type="radio"/> Partial	_____ mm

07. If tension band plate used, what type?

- 3.5 mm recon plate
- 4.5 mm recon plate
- 3.5 mm DCP, LCDCP (or similar)
- 4.5 mm DCP, LCDCP (or similar)

08. If transiliac bars or screw(s) used, what type?

- Fully threaded large diameter pin (*Skip to question 10*)
- Transiliac partially or fully threaded screw(s)

9. If “partially or fully threaded transiliac screw”, specify number, length, and diameter

- a. Number** ___ #
- b. Length** ___ mm
- c. Diameter** ___ . ___ mm

10. For lumbopelvic fixation, proximal extension to what level?

- L5
- L4
- L3

11. Was sacral decompression performed?

- Yes
- No (*Skip to question 13*)

12. If sacral decompression was performed, to which nerve roots? (*Mark all that apply*)

- Laminectomy only
- L5
- S1
- S2
- S3

Please continue on next page

Patient Study ID = _____

Date Completed (MM/DD/YY) = _____

Completed By: _____

ANTERIOR RING INJURY*Complete questions 13-19 for anterior ring injury treated operatively***Patient Positioning and Exposure****13. Was fixation performed?**

- Yes
- No

14. Technique for reduction

- Open (anterior surgical exposure)
- Closed (no surgical exposure for reduction)

15. If “open reduction”, what was the surgical approach?

- Pfannenstiel or Stoppa
- Iliolumbar (e.g. middle window)
- Iliac
- Other

Reduction*If Closed Reduction, answer 16.***16. Closed reduction achieved via:**

- Patient positioning only (i.e. in situ fixation)
- External fixation
- Percutaneous bone hook or schantz pin
- Femoral distraction
- Limb skeletal traction

*If Open reduction, answer 17***17. Open reduction achieved via:**

- Direct visual reduction with clamp application
- Indirect manipulation with external fixation
- Other

Implants Used*If Closed Reduction, answer 18.***18. Implants used after Closed Reduction**

- 3.5 mm cortical screws (e.g. retrograde ramus screws)
- 4.5 mm cortical screws (e.g. retrograde ramus screws)
- External fixation

*If Open Reduction, answer 19.***19. Implants used after Open Reduction (Mark all that apply)**

- 3.5 mm reconstruction plate
- 3.5 mm locking plate
- 3.5 mm DCP or LCDCP (or similar)
- 3.5mm cortical ramus screw
- 4.5 mm cortical ramus screw
- External fixation

Please continue on next page

Patient Study ID = _____

Date Completed (MM/DD/YY) = _____

Completed By: _____

Complete questions 20-29 for ALL

20. If open fracture or ML lesion (posterior or anterior), date and time of irrigation and debridement

a. Date ____ / ____ / ____ (MM/DD/YY)

b. Time ____ : ____ AM / PM (circle one)

21. Date and time of definitive fixation

a. Date ____ / ____ / ____ (MM/DD/YY)

b. Time ____ : ____ AM / PM (circle one)

22. Length of surgery (skin to skin) ____ min

23. Fluoroscopy time ____ seconds

Additional surgical procedures

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
24. Fixation of upper extremity fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Fixation of lower extremity fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Fixation of spine fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Did the patient have abdominal surgery?

Yes No

28. Did the patient have any other surgical procedures?

Yes (Specify): _____
 No

29. Planned secondary surgeries (Mark all that apply)

- None
- Irrigation and debridement
- VAC placement
- Additional fixation
- Other (Specify below)

Please continue on next page

Patient Study ID = _____

Date Completed (MM/DD/YY) = _____

Completed By: _____

POSTOPERATIVE EVALUATION

01. If iliosacral screw(s) used, (Mark all that apply for each screw)

<u>Complete a. – e. for each screw used</u>	<u>Iliosacral Screws</u>				
	1	2	3	4	5
a. Screw Position Safe (complete intraosseus)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Screw juxtaforaminal at S1, S2, or S3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Screw violates the neuroforaminal tunnel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Screw violates the cephalad cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Screw violates the anterior sacral cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For c, d, and/or e, describe:

02. If tension band plate used,

- Hardware is well-positioned and without error
- Hardware error (describe):

03. If transiliac bars or plates used,

- Hardware is well-positioned and without error
- Hardware error (describe):

04. If lumbopelvic fixation used,

- Hardware is well-positioned and without error
- Hardware error (describe):

Patient Study ID = _____

Date Completed (MM/DD/YY) = _____

Completed By: _____

TREATMENT DECISION

1. If the patient was treated operatively, what was the primary reason you chose this treatment? (Please check one)

- Deformity unacceptable upon presentation circle all that apply: (**rotational / translational / sitting imbalance**)
- Prevention of potential deformity (presumed instability)
- Acute Pain relief
- Avoidance of future pain
- Unable to mobilize without fixation
- Instability as assessed on a push pull radiograph
- Multiple trauma patient
- Neurologic deficit
- For stabilization due to soft tissue injury
- Other: _____

2. If the patient was treated operatively, what was the second most important reason you chose this treatment? (Please circle one)

- Deformity unacceptable upon presentation circle all that apply: (**rotational / translational / sitting imbalance**)
- Prevention of potential deformity (presumed instability)
- Acute Pain relief
- Avoidance of future pain
- Unable to mobilize without fixation
- Instability as assessed on a push pull radiograph
- Multiple trauma patient
- Neurologic deficit
- For stabilization due to soft tissue injury
- Other: _____

Sacral Fracture Study

Data Collection Grid

<i>Case Report Form</i>	<i>Completed By</i>	<i>Pre-Injury</i>	<i>Day of¹ Surgery</i>	<i>Post-Tx (24hrs)</i>	<i>1² week</i>	<i>3² weeks</i>	<i>6 weeks</i>	<i>3 mo</i>	<i>6 mo</i>	<i>12 mo</i>	<i>24 mo</i>
Inclusion/Exclusion Criteria	Physician	X									
Patient Information Form	Physician	X									
Patient Injury Form	Physician	X									
Fracture Characteristics Form	Physician	X									
Radiographic Evaluation Form	Physician	X (inc. CT)		X ¹ (3 Views)			X (AP only)	X (3 Views)	X (AP ⁴)	X (AP only)	
Majeed Pelvic Score	Patient	X						X	X	X	X
SMFA	Patient	X						X	X	X	X
VAS	Patient	X		X ³	X	X	X	X	X	X	X
Treatment Summary	Physician		X ³								
Follow-up Clinical Evaluation	Physician						X	X	X	X	X
Adverse Event	Physician	As Needed									

1 - Operative patients only

2 - Can be done by mail

3 - For all patients regardless of treatment

4 - Inlet and Outlet required only if change in reduction

