Australasian Shunt Registry Data Collection Form
Neurosurgical Society of Australasia

PATIENT INFORMATION

ATTACH PATIENT LABEL

OR

COMPLETE DETAILS

PATIENT ADDRESS MUST BE INCLUDED

Patient UR	
Surname	
Forename	
Date of Birth	d d m m y y y y
Gender	Male ☐ Female ☐
Street Address	
Suburb	Postcode
No fixed Address ☐	Address not known ☐

Medicare Number _____

HAS THE PATIENT BEEN GIVEN A PATIENT INFORMATION /OPT-OUT FORM?
Yes ☐ No/Unsure ☐ (ASR will send to patient/guardian)

CLINICAL DIAGNOSIS

Please indicate the PRIMARY aetiology of CSF circulation disorder

Congenital	Aqueduct stenois ☐	Dandy Walker ☐	Chiari ☐	Chiari/Spina Bifida ☐	Other specify
Acquired	Infection ☐ ⇨	Meningitis ☐	Post-surgical ☐	Abscess ☐	Other specify
	Haemorrhage ☐ ⇨	Site IVH ☐	Site AVH ☐		
	Aetiology ⇨	Perinatal ☐	Aneurysm ☐	AVM ☐	Other specify
	Tumour ☐ ⇨	Supratentorial ☐	Post Fossa ☐	Other	specify
Other	Pseudotumor cerebri ☐	Trauma ☐	Arachnoid cyst ☐	Idiopathic Normal Pressure Hydrocephalus ☐	
	Other _____specify_____				

OPERATION DETAILS

Date	d d m m y y y y Estimate ☐ Accurate ☐	**Start time** Estimate ☐ Accurate ☐	h h m m	***or* Total duration**
		End time Estimate ☐ Accurate ☐	h h m m	_____ hrs _____ mins
Operating Surgeon (name)		**Hospital Name**	Consultant only ☐	Consultant and Trainee ☐
			Trainee only ☐	Trainee – multiple ☐

Operation	Shunt Insertion ☐	Shunt revision* ☐	Shunt removal ☐	Shunt externalisation ☐
	External ventricular drain ☐	Subtemporal Decompression☐	Endoscopic 3rd Ventrioculostomy ☐	Choroid plexectomy☐
	Other specify			
Image guidance	Yes ☐ No ☐			
Antibiotic Use	Pre-operative ☐	IV Intra-operative ☐	Irrigation fluid intraoperative ☐	Post operative ☐

SHUNT DETAILS *(after insertion/revision*)*

Antibiotic Impregnanted Catheter? Yes ☐ No ☐

Proximal Catheter	Ventricle	Right ☐	Left ☐	Fourth ☐	Frontal ☐	Parietal ☐	Other specify
	Other sites	Cyst ☐	Lumbar ☐	Subdural ☐	Cisterns ☐	Other	specify
Distal Catheter	Peritoneum ☐	Atrium ☐	Thorax ☐	External ☐	Other	specify	
Valve ☐ ⇨	Programmable ☐	Non Programmable ☐					
	Integral Reservoir ☐	Separate Reservoir ☐					
Or Valveless ☐	Antisiphon device ☐	Opening Pressure _____					

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***If this operation is a shunt REVISION please complete additional details over the page ➔**

Please enter details of all products used ➔

FOR SHUNT REVISIONS ONLY

Indications/Findings	**Infection** ☐					
Blockage/Underdrainage ☐	⇨	Proximal ☐	Distal ☐	Valve ☐		
Overdrainage ☐	⇨	Slit ventricles ☐	Subdural hygromas ☐	Subdural haematomas☐	Low pressure symptoms only ☐	
Disconnection ☐	⇨	Proximal ☐	Distal ☐	**Fracture**☐ ⇨	Proximal ☐	Distal ☐
Catheter Misplacement ☐	⇨	Proximal ☐	Distal ☐	Other specify		

OTHER

Form completed by: Date:

PRODUCT DETAILS

Affix product stickers or complete details for all components used in this procedure

Affix SHUNT SYSTEM Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix PROXIMAL/VENTRICULAR CATHETER Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix VALVE Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix DISTAL CATHETER Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix ANTISIPHON device Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix OTHER COMPONENT Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

Affix OTHER COMPONENT Sticker
(Complete below if sticker not available)

Manufacturer:_____

Cat #:_____

Serial #:_____

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RETURN FORM:

Fax:	03 9642 5611
Scan and Email :	shunt.registry@nsa.org.au
Post to:	
No stamp required	Shunt Registry (NSA) PO Box 90824 Melbourne VIC 3000

Database use only: Patient ID Number _____

Master ASR Data collection form V2 14042016