



# HIP SURVEILLANCE PROGRAM

for Children with Cerebral Palsy

For office use only:

## ENROLLMENT FORM

Hip surveillance is a plan for regular check-ups using clinical exams and hip x-rays to watch for signs that your child's hip may be moving out of joint. You/your child have been invited to participate in the **Child Health BC Hip Surveillance Program** because you/your child has been identified as being at risk for having the hip move out of joint.

I, \_\_\_\_\_, hereby agree to participate/have my child \_\_\_\_\_ participate in the Child Health BC Hip Surveillance Program, which means (**please initial in boxes below**):

- I have been provided with the booklet “**What is Hip Surveillance and Why is it Important for My Child?**”
- I have been given the opportunity to ask questions and have had satisfactory response to my questions.
- I understand that this will involve regular clinical exams of my/my child's hips by my/my child's physiotherapist or other health care provider.
- I understand that this will involve the review of my/my child's hip x-rays and relevant health information by the program's physician and/or coordinator at BC Children's Hospital.
- I understand a report will be provided to me and to my/my child's physiotherapist (when completing the clinical exams), primary care provider (Family Doctor or Pediatrician), and orthopaedic surgeon as listed here by me. Please provide contact information for these healthcare providers:

Physiotherapist	Agency and City	Phone
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Physician Name	Address and City	Phone
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Ortho Surgeon Name	Address and City	Phone
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**Consent for Mailing:** May we send you information on new resources and/or research that may be of benefit to you and your child related to cerebral palsy and/or hip health?  Yes  No

If yes, please indicate your preferred method of delivery:  
 mail  email, please provide your email address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Child/Youth

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Name of Legal Guardian (Print)

\_\_\_\_\_  
Date

(\_\_\_\_) \_\_\_\_\_  
Telephone Number

The information on this form is collected for the purpose of enrolling in the Child Health BC Hip Surveillance Program. It is collected under the authority of section 26(c) of the BC Freedom of Information and Protection of Privacy Act. For additional information, please see [www.childhealthbc.ca/hips](http://www.childhealthbc.ca/hips) or contact the program coordinator by email: [hips@cw.bc.ca](mailto:hips@cw.bc.ca) or phone: 604-875-2345 extension 4099.



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ENROLLMENT FORM

Child/Youth's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (dd/mth/yr)

TO BE COMPLETED BY THE INTERPRETER (if applicable):

I confirm that I have explained the nature of the above consent to the above-named patient (and/or legal guardian) in the presence of \_\_\_\_\_ and to the best of my knowledge the context of this consent form is understood.

Witness Name (Print)

\_\_\_\_\_  
Signature of Interpreter

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Day                      Month                      Year

\_\_\_\_\_  
Interpreter Name (Print)

Please return completed Enrollment Package to:

Child Health BC Hip Surveillance Program

Fax: 604-875-2387

Mail: BC Children's Hospital  
Orthopaedic Department, Room ID62  
4480 Oak Street  
Vancouver, BC  
V6H 3V4

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## ENROLLMENT FORM CLIENT INFORMATION

Date: \_\_\_\_\_ (dd/mth/yr)

Last Name: \_\_\_\_\_ First & Middle Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (dd/mth/yr) PHN: \_\_\_\_\_

Gender:  Male  Female  Other \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Born in BC:  Yes  No If No, arrived in BC in: \_\_\_\_\_ (mth/yr)

### Contact Information

Primary Caregiver's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to the Child: \_\_\_\_\_ Legal Guardian  Yes  No

Mailing Address: ( same as above) \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Home  Cell  Work

Phone Number: \_\_\_\_\_  Home  Cell  Work

Email: \_\_\_\_\_

Interpreter Required:  Yes  No If yes, language \_\_\_\_\_

Alternate Caregiver's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to the Child: \_\_\_\_\_ Legal Guardian  Yes  No

Mailing Address ( same as above) \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_  Home  Cell  Work

Phone Number: \_\_\_\_\_  Home  Cell  Work

Email: \_\_\_\_\_

Interpreter Required:  Yes  No If yes, language \_\_\_\_\_

Would you like correspondence go this mailing address?  Yes  No (if no, primary address will be used)

### MCFD/DAA Involvement

MCFD/DAA involvement:  Yes  No

If yes, Social Worker Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

SW is Legal Guardian:  Yes  No If yes, does foster parent have authority to make non invasive healthcare decisions (e.g. consent to an x-ray)?  Yes  No (please ask foster parent to confirm this)

Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (Work) Phone Number: \_\_\_\_\_ (Cell)

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Would you like correspondence go to this mailing address?  Yes  No (if no, primary address will be used)

### Relevant History

Has the child/youth had a hip/pelvis x-ray in the past?  Yes  No  Unknown

If yes, Date of most recent x-ray: \_\_\_\_\_ (dd/mth/yr)

Hospital/Clinic where x-ray completed: \_\_\_\_\_

Has the child/youth seen an Orthopaedic surgeon in the past?  Yes  No  Unknown

If yes, surgeon's name: \_\_\_\_\_

Is the child still followed by this surgeon?  Yes  No Next appointment (approximate): \_\_\_\_\_

Has the child had surgical intervention for hip displacement?  Yes  No

If yes, list (including approx. date): \_\_\_\_\_

\_\_\_\_\_

### Enrolling Clinician Information

Name: \_\_\_\_\_  PT  OT  MD  Other: \_\_\_\_\_

Agency: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ Postal Code: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Did you identify this child for hip surveillance?  Yes  No

If No, who identified?  PT  OT  MD  Parent  Other \_\_\_\_\_ Name: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ First & Middle Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (dd/mth/yr) PHN: \_\_\_\_\_

**\*\*See the CLINICAL EXAM INSTRUCTIONS for definitions and exam descriptions\*\***

**Diagnosis:**  Cerebral Palsy (CP)  Possible CP, not yet confirmed  Other\* (specify) \_\_\_\_\_

*\*If known, specify name of child's condition/syndrome. Note: children diagnosed with known conditions (e.g genetic, metabolic, chromosomal, etc) may also be described as having CP if their clinical presentation is consistent with the definition of CP*

**Step 1: Classify:**

a) GMFCS level **\*\*REQUIRED\*\*** (select one):  I  II  III  IV  V

b) MACS level, if known (select one):  I  II  III  IV  V

c) CFCS level, if known (select one):  I  II  III  IV  V

d) Motor Distribution:

Unilateral (hemiplegia)

OR

Bilateral

↓  
If unilateral:

i) Affected side:  Right  Left

ii) Type IV hemiplegic gait?  No  Yes

↓  
If bilateral, select all affected limbs:

Right Upper  Left Upper

Right Lower  Left Lower

e) Motor type (Select all that apply):

Spasticity

Dystonia

Athetosis

Chorea

Ataxia

Hypotonia

**Step 2: Assess:**

a) Hip abduction ROM (hips & knees at 0° flexion): Right: \_\_\_\_\_°, Left: \_\_\_\_\_°  Not tested *\*If not tested or unable to test reliably, please provide a brief reason in the Comments section below.*

b) Pain present during clinical exam:  Yes  No  Unknown  Not tested

**Step 3: Ask the child and/or child's parent/primary caregiver**

1. Do [does] you [your child] have hip pain? You may notice this when you move [your child moves] your [their] hip or after prolonged activity, when changing your [your child's] position, when you move you [your child's] leg or when looking after your [your child's] personal care.  Yes  No  Unknown

**Comments:** \_\_\_\_\_

\_\_\_\_\_

Date of Clinical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mth/yr) Completed by: PT OT MD Other \_\_\_\_\_

Clinician's Name: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Assisting Clinician's Name (if applicable): \_\_\_\_\_