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
Physician Name	Address and City	Phone
Ortho Surgeon Name	Address and City	Phone

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 or contact the program coordinator by email: hips@cw.bc.ca or phone: 604-875-2345 extension 4099.

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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
Witness Name (Print)
of my knowledge the context of this consent form is understood.

________________________________ _______/______________/__________
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: _________________________________

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)*

Fax completed forms to: 604-875-2387

 Name: ____ DOB: _____/_____/_______ (dd/mth/yr)

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: _____________________________

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CLINICAL EXAM

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 *(select **one**)*: ❑ I ❑ II ❑ III ❑ IV ❑ V

b) Motor Distribution: ❑ Unilateral (hemiplegia) ❑ Bilateral

If unilateral:

i) Affected side: ❑ Right ❑ Left

ii) Group IV hemiplegic gait? ❑ No ❑ Yes

If bilateral, select all affected limbs:

❑ Right Upper ❑ Left Upper

❑ Right Lower ❑ Left Lower

c) Motor type *(Select **all** that apply)*: ❑ Spasticity ❑ Dystonia ❑ Athethosis ❑ Chorea ❑ Ataxia ❑ Hypotonia

Step 2: Measure:

a) Hip abduction (hips & knees at 0° flexion): Right: R1 = _______°, R2 = _______ ° ❑ Not tested

Left: R1 = _______°, R2 = _______ ° ❑ Not tested

b) Modified Thomas test: Right side test is positive: ❑ No ❑ Yes, if yes: ________ ° ❑ Not tested

Left side test is positive: ❑ No ❑ Yes, if yes: ________ ° ❑ Not tested

**If not tested or unable to test reliably, please provide a brief reason in the Comments section below.*

Step 3: Ask the child and/or child's parent or primary caregiver *(from last clinical exam or prior 6 months)***:**

1. Do you/your child have hip pain? You may notice this when changing your child's position, when you move your child's leg or when looking after your child's personal care. ❑ Yes ❑ No
2. Do you have more difficulty looking after your/your child during personal care, dressing, bathing or other activities that involve moving your/their hip? ❑ Yes ❑ No
3. Has there been a decrease in your/your child's ability to walk, sit or stand, which is related to the hip? ❑ Yes ❑No

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):______________________________________

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