CHILD HEALTH BC
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HIP SURVEILLANCE PROGRAM

for Children with Cerebral Palsy

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 **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

b) Pain present during clinical exam: ❑ Yes ❑ No ❑ Unknown ❑ 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/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: ____

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Date of Clinical Exam: ______/_______/______ (dd/mth/yr) Completed by: ❑PT ❑OT ❑MD ❑Other ______________

Clinician's Name: ____

Agency: ______________________________ Phone: ______________________________

Assisting Clinician's Name (if applicable): ______________________________

Fax completed forms to: 604-875-2387