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:

<table>
<thead>
<tr>
<th>Physiotherapist</th>
<th>Agency and City</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name</td>
<td>Address and City</td>
<td>Phone</td>
</tr>
<tr>
<td>Ortho Surgeon Name</td>
<td>Address and City</td>
<td>Phone</td>
</tr>
</tbody>
</table>

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.
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.

__________________________________ _______/_______________/__________
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)

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Fax completed forms to: 604-875-2387
Enrollment Form Page 2  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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**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:**

<table>
<thead>
<tr>
<th></th>
<th>Unilateral (hemiplegia)</th>
<th>OR</th>
<th>Bilateral</th>
</tr>
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</tbody>
</table>

  - 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

**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 [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:** __________________________________________

**Assisting Clinician’s Name (if applicable):** __________________________________________

Fax completed forms to: 604-875-2387