CHILD HEALTH BC
LEAD BENEFACTOR save on foods

HIP SURVEILLANCE PROGRAM

for Children with Cerebral Palsy

PROVIDER REFERRAL FORM

Date:_____/_____/_____(dd/mth/yr)

Patient Information

Last Name: _____First & Middle Names: _____

Date of Birth: _____ (dd/mth/yr) PHN: _____

Gender: ❑ Male ❑ Female ❑ Other _____

Mailing Address*:* _____

City: _____ Postal Code: _____

Caregiver Information

Primary Caregiver's Last Name: _____ First Name: _____

Mailing Address*:* (❑ same as above) _____

Phone Number: _____ ❑ Home ❑ Cell ❑ Work

Interpreter Required: ❑ Yes ❑ No If yes, language_____

Relationship to the Child: _____ Legal Guardian ❑ Yes ❑ No

If No, Legal Guardian Name: _____ Relationship to Child: _____

Physiotherapist's Name (if known): _____ Agency: _____

Diagnosis: ❑ Cerebral palsy, child is appropriate for hip surveillance

❑ Possible cerebral palsy, seeking advice re: appropriateness for surveillance

Additional Information (please provide details of motor impairment): _____

_____

_____

_____

_____

Referring Provider Information

Name: _____ ❑ PT ❑ OT ❑ MD ❑ Other: _____

Agency: _____

Street Address*:* _____

City _____ Postal Code: _____

Work Phone Number: _____ Alternative Phone: _____

Fax Number: _____ Email: _____

PLEASE FAX COMPLETED FORM TO: CHBC Hip Surveillance Program Coordinator at 604-875-2387

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