NOVA SCOTIA HIP SURVEILLANCE PROGRAM REGISTRATION FORM

Date: _____

Child's Last Name: _____ First and Middle Names: _____

Date of Birth (dd/mm/yr.): _____ HCN: _____

Gender: ☐ Male ☐ Female ☐ Other _____

Mailing Address: _____

City: _____ Postal Code: _____

Local Hospital: _____

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): _____

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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 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/mm/yr)

Hospital where x-ray completed: _____

Has the child/youth seen an orthopedic 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 2pprox.. date) _____

Enrolling Health Care Provider Information

Name: _____ ☐ PT ☐ OT ☐ MD ☐ Other _____

Agency & mailing address:

City: _____ Postal Code: _____

Work Phone Number: _____ Fax Number: _____ Email: _____

Please fax completed form to Rehabilitation Services, IWK: 902-470-8348 or click Submit Form button

Version 1.0 October 2023

Submit Form