Nova Scotia Hip Surveillance Program: Clinical Exam

Child's Name: _____ Date of Birth dd/mm/yr: _____

Date of Clinical Exam: _____ Site: _____

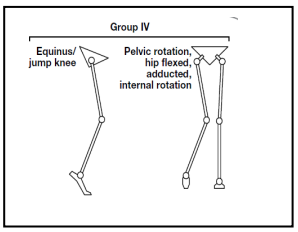
Diagnosis: ☐ Cerebral Palsy (CP) ☐ Possible CP, not yet confirmed ☐ Other* (specify)_____

**If known, specify name of child's condition/syndrome. Note: children diagnosed with known conditions (e.g. genetic, metabolic, chromosomal,* 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. Motor Distribution



☐ **Unilateral (hemiplegia)**

i. Affected side: ☐ Right ☐ Left

ii. Type IV hemiplegic gait?: ☐ No ☐ Yes

OR

☐ **Bilateral**

If bilateral select all affected limbs:

☐ Right Upper ☐ Left Upper

☐ Right Lower ☐ Left Lower

c. Motor type (select **all** that apply) :

☐ Spasticity ☐ Dystonia ☐ Athetosis

☐ Chorea ☐ Ataxia ☐ Hypotonia

Step 2: Assess

a. Hip abduction ROM (hips and 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 rest reliably provide a reason in the comments section below.*

Step 3: Ask the child and/or the child's parent/primary caregiver

"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 [your child's] leg or when looking after your [your child's] personal care." ☐ Yes ☐ No ☐ Unknown

Comments:

Completed by: ☐ PT ☐ OT ☐ MD ☐ Other Clinician's Name: _____

Clinician's Phone: _____ Clinician's email address: _____

Consent has been provided to provide this clinical information to the IWK Hip Surveillance Program. ☐

Please submit completed form to Rehabilitation Services, IWK:

Fax: **902-470-8348**

Email: CPHipSurveillance@iwk.nshealth.ca