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 email to cphipsurveillance@iwk.nshealth.ca