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: ____

Local Physiotherapist (Name): ____

Local Occupational Therapist (Name): ____

Contact Information

Primary Caregiver's Last Name: __________________________________ First Name: _______________________

Relationship to the Child: ______________________________ Legal Guardian: ☐ Yes ☐ No

Phone Number: __________________________ ☐ Home ☐ Cell ☐ Work

Email: ____

Interpreter Required: ☐ Yes ☐ No If yes, language: ____

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Relevant History

Has the parent/caregiver given consent to be registered in the program ◻ Yes ◻ No

Is the parent/caregiver aware of child's diagnosis ◻ Yes ◻ No

What is the child's GMFCS level? ◻ I ◻ II ◻ III ◻ IV ◻ V ◻ UNKNOWN

Enrolling Health Care Provider Information

Name: ______________________________ ◻ PT ◻ OT ◻ MD ◻ NP

Agency & mailing address: ____________________________

City: ____ Postal Code: ____________________

Work Phone Number: __________ Fax Number: ______________Email: ______________________

Please fax completed form to Rehabilitation Services, IWK: 902-470-8348

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