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

Version 4.0 June 2016