



Specialized Services  
for Children & Youth  
Together Is Better

Rehabilitation Centre for Children  
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**Manitoba Hip Surveillance – Physical Exam** **GMFCS 4-5**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Involvement: (Unilateral/Bilateral) \_\_\_\_\_

Date:		
Physiotherapist:		
GMFCS:		

	RIGHT	LEFT	RIGHT	LEFT
<b>HIP - supine</b>				
THOMAS TEST/Hip flexion deformity <-10° -10°-0° >0°				
ABDUCTION – Hips and knees flexed Slow passive movement (R2) <20° 20°-30° >30°				
ABDUCTION –Hips and knees extended Slow passive movement (R2) <20° 20°-30° >30°				
GALEAZZI TEST (positive/negative)				
INTERNAL ROTATION - Hip flexed to 90° <30° 30°-40° >40°				
EXTERNAL ROTATION - Hip flexed to 90° <30° 30°-40° >40°				
POPLITEAL ANGLE - Slow passive movement (R2) >60° 40°-50° <40°				
Popliteal angle fast (R1)				
PAIN ON HIP RANGE OF MOTION (yes/no)				
<b>KNEE - supine</b>				
Extension (Fixed Flexion) >10° FFD 1-10°FFD 0°				
Knee Hyperextension (degrees)				

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Date:		
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	RIGHT	LEFT	RIGHT	LEFT
<b>ANKLE/FOOT-supine</b>				
DORSIFLEXION – Knee extended Slow Passive Movement <b>&lt;-10° -10°-0° &gt;0°</b>				
Dorsiflexion- knee extended fast (R1)				
DORSIFLEXION – Knee flexed Slow Passive Movement <b>&lt;0° 0°-10° &gt;10°</b>				
<b>HIP - prone</b>				
DUNCAN ELY Slow passive movement (R2) <b>&lt;90° 90°-100° &gt;110°</b>				
Duncan Ely fast (R1)				
EXTENSION <b>&lt;10° -10°-0° &gt;0°</b>				
<b>SPINE – Yes/No</b>				
Scoliosis sitting				
Lumbar lordosis excessive				
Thoracic kyphosis excessive				
FUNCTIONAL MOBILITY SCALE (FMS)	5m		5m	
	50m		50m	
	500m		500m	

**RED: Requires further assessment by orthopedics**

**AMBER: Review child’s management strategy**

**GREEN: Normal or near normal value**

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>Date:</b>		
<b>Physiotherapist:</b>		
<b>GMFCS:</b>		

<b>Caregiver Concerns:</b>		
<b>Equipment:</b>	<b>Stander:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Walker:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Stander:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Walker:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Orthotics currently used:</b>		
<b>Date of last hip x-ray:</b>		
<b>Next hip x-ray due:</b>		

**SIGNED:** \_\_\_\_\_ **DESIGNATION:** \_\_\_\_\_