Developmental Dysplasia of the Hip (DDH)

Referral request to

☐ GP: ☐ Paediatrician:

☐ Paediatric orthopaedic outpatient clinic:

Address: Postcode:

Fax:

Child's details

Surname: Given names:

Date of birth: Gender: Male ☐ Female ☐

Address: Postcode:

Daytime phone number: Mobile phone number:

Risk factors for DDH *(please tick)*

☐ Family history of DDH in first degree relative ☐ Breech presentation ☐ Packaging deformity (e.g. torticollis, plagiocephaly, foot deformity)

☐ Multiple pregnancy ☐ First born

Clinical findings

Tick	Left	Right
Positive Barlow sign	☐	☐
Positive Ortolani sign	☐	☐
Limited hip abduction	☐	☐
Clicky hip	☐	☐
Leg length shortening	☐	☐

Asymmetric thigh fold	☐	(Tick if present)
Asymmetric gluteal fold	☐	(Tick if present)

Other (please comment)

Investigations performed

☐ X-ray ☐ Ultrasound

Date of investigation:

Report Attached: ☐ Yes ☐ No

Referrer details

Name:

Position:

Organisation:

Address:

Postcode:

Phone number:

Referrer's signature: Date: