Developmental Dysplasia of the Hip (DDH) — *Referral Form*

Referral Source

Name:	Position:
Organisation:	
Address:	
	Phone Number:

Child's Details

Surname:	Given Names:
Date of Birth:	Gender (please tick): ◯ Male ◯ Female
Parent/Guardian's full name:	
Address:	
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
- ◯ Female
- ◯ First born
- ◯ No risk factors

Clinical Findings

Tick	Left	Right
Positive Barlow sign	◯	◯
Positive Ortolani sign	◯	◯
Limited abduction in flexion	◯	◯
Clicky hip	◯	◯
Leg length shortening	◯	◯
Asymmetric thigh fold	◯	(Tick if present)
Asymmetric gluteal fold	◯	(Tick if present)

Other (please comment)

Results of relevant investigations *(attach report)*

Date of investigation:

Services Required

Tick	
◯	General Practitioner
◯	Paediatrician
◯	Paediatric orthopaedic outpatient clinic
◯	Ultrasound (if < 6 months)
◯	Radiograph (if ≥ 6 months)

Please attach copies of any relevant investigations/reports/letters

Referrer's signature: Date: