Dear Doctor

Thank you for arranging to see this infant who is at increased risk of Developmental Dysplasia of the Hip (DDH) on the basis of:

- [ ] Breech lie
- [ ] Positive Family History of DDH in first degree relative
- [ ] Other, specify………………………………………………
- [ ] Abnormal Hip exam, specify……………………………

Infants are only seen AFTER they reach 6 weeks post-term. For premature infants this will be 6 weeks after their estimated date of delivery (EDD).

Born at Term? Yes / No If No, what was the gestational age at birth? _____ (weeks).

Approximate date to be seen: ___/___/___

This referral has been discussed with Neonatal Consultant/SR. Dr………………………………
Signature…………………………………… Date/Time……………………
Print name………………………….. Position/Designation……………………………………