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…………………………………

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This version: Jan 2015