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…………………………….