

Please fax and copy to notes and then place in internal post addressed to:  
Rowley Bristow Orthopaedic Unit  
Fax number: **01932 722 689**

**REFERRAL TO ORTHOPAEDIC TEAM FOR DETECTION OF DEVELOPMENTAL  
DYSPLASIA OF THE HIP**

Name of baby: .....

D.O.B: .....

Hospital number: .....

Address: .....

.....

Telephone number: .....

Consultant: .....

G.P. ....

Reason for referral:

- 1. **Dislocated / dislocatable hip on examination**   
**(Please note these will be seen as a priority)**
- 2. Clicky Hips on examination
- 3. Babies with a family history of DDH
- 4. Breech delivery (any gestation)
- 5. Breech position at or after 36 weeks regardless of delivery presentation
- 6. Both twin siblings if any delivered breech   
*(Please refer both twins even if one twin was breech presentation or has abnormal hip examination with two separate forms)*
- 7. Muscle Weakness/ other deformity

Please provide clinical details / examination findings:

Referring doctor (Please print): .....

Signature .....

Date of referral .....

Please provide parents with [information leaflet](#) and telephone number of the Rowley Bristow Orthopaedic Outpatient appointment line (01932 722 730)