Government of **Western Australia**
Department of **Health**
North Metropolitan Area Health Service

Addressograph Label

HIP REFERRAL FORM

Attention:	Orthopaedic Clinic PMH	**From:**	**NEONATOLOGY CLINICAL CARE UNIT KEMH (SCN)**
Phone:	9340 8578/8853 (Clerk) 9340 7585 (Nurse)	**Phone:**	9340 2099
Fax:	9340 8854	**Fax:**	9340 1493
Pages:		**Date:**	

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…….

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

Approximate date to be seen: __/__/__

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).

This referral has been discussed with Neonatal Consultant/SR. Dr…….

Signature…… Date/Time……..

Print name…….. Position/Designation…….....