



Women's and Children's Health Service

Neonatology Clinical Care Unit - PMH

Attention:	Orthopaedic Clinic PMH	From:	Ward 6B
Phone:	9340 8578	Phone:	9340 8536
Fax:	9340 8854	Fax:	9340 7852
Pages:		Date:	

HIP REFERRAL FORM

Dear Doctor

RE:

Address Label

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.....

All referrals where an infant is found to have a clinically unstable hip will be made by direct telephone contact to a member of the Dept of Orthopaedics at PMH, this form being confirmation of that contact:

- Person contacted:..... Date..... Time.....

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

Print name.....Position.....Date.....

Signature.....