GP Letter

Notification of Referral for Developmental Dysplasia of the Hips (DDH)

GP Name:……..

GP Address……

……..

……..

Addressograph Label

Date ...../ ...../.....

Dear Dr ..... ,

Thank you for your ongoing care of this family. This baby was identified as:

☐ Having a 'clicky' (Left / Right / Both) hip(s) which was stable and en-located on clinical examination at discharge;

- Infants in this category **have had a faxed referral made by KEMH** to the DDH (Orthopaedic) clinic at Princess Margaret Hospital for clinical review ± ultrasound in 6 weeks.

☐ Having an unstable (Left / Right / Both) hip(s) on clinical examination at discharge;

- Infants in this category **have been referred immediately by telephone** to the Orthopaedic Unit at Princess Margaret Hospital, for early confirmation and management.

☐ A normal hip examination but has risk factors for DDH, including:

☐ Breech lie *in utero*

☐ DDH in 1st degree relative

☐ Other reason .....

- Infants in this category **have had a faxed referral made by KEMH** to the DDH (Orthopaedic) clinic at Princess Margaret Hospital for clinical review ± ultrasound in 6 weeks.

Thank you for your ongoing care of this family.

Regards,

Signature ..... Designation .....

Print Name.....

Staff of the Neonatology Directorate, KEMH

Hip Referral Form

Addressograph Label

Attention:	Orthopaedic Clinic PMH	**From:**	**King Edward Memorial Hospital**
Phone:	9340 8578/8853 (Clerk) 9340 7585 (Nurse)	**Phone:**	6458 2099
Fax:	9340 8854	**Fax:**	6458 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 .....

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 Department of Orthopaedics at PMH, this form being confirmation of that contact:

Person contacted..... Date/Time .....

Gestation at Time Of Delivery ..... Weeks ..... Days (Note: Scan is 6 weeks from EDD).

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

Print name.....

Signature..... Position/Designation.....

Date/Time..... Provider Number.....