MR005.97u

Ballarat Health Services
Putting your health first

Outpatient Developmental Dysplasia of Hip Clinic Referral

U.R. Number _____

Surname _____

Given Names _____

D.O.B. / / Sex _____

AFFIX PATIENT LABEL HERE

Request date: _____/_____/_____

Date received:_____/_____/_____

Referral entered on IBA ☐

Office use only

Birth history

G_____ P_____ Gestation: _____ /40 NVD/ el. LUSCS/ em. LUSCS Birth weight: _____ g

Risk factors

Family Hx (1st degree relative) ☐ Breech ☐ First born ☐ Female ☐

Intrauterine restriction: Oligohydramnios ☐
Multiple birth ☐

Clinical Examination

	Right	Left
NAD	☐	☐
Hip enlocated subluxable (laxity)	☐	☐
Hip enlocated dislocatable (+ve Barlow)	☐	☐
Hip dislocated reducible (+ve Ortolani)	☐	☐
Hip dislocated irreducible	☐	☐
Restricted hip ABDuction in flexion	☐	☐
Foot abnormality	☐	☐
Posturing including torticollis/plagiocephaly	☐	☐
Leg length shortening (+ve Galeazzi)	☐	☐

Other congenital abnormality: _____

Additional information

_____

_____

Radiology ultrasound request completed, signed and attached ☐

Referrer details

Referring Clinician: _____ Referring ward/clinic: _____

Provider No: _____ Pager: _____

Designation: _____ Signature: _____

Clinic use only

Developmental Dysplasia of Hip clinic Clinical ☐

US ☐

Booking: Date: ___/____/_____ Time: _____

Outcome Actioned: Date: ___ / ___ /___ **By:** _____

BHS PS
Jun 15

REFERRAL DEVELOPMENTAL DYSPLASIA OF HIP CLINIC MR/005.97