Developmental Dysplasia of the Hip (DDH) Referral Form
Orthopedic Clinic BC Children's Hospital
Fax 604-875-2275

Patient Name ___________________
PHN ___________________
DOB ___________________

Referral Criteria: breech, family history, and/or abnormal exam

Referral Reason for DDH Screening

Risk Factors	☐ breech ☐ family history: ________________ ☐ female ☐ first born ☐ other: ________________	
Abnormal Exam	**RIGHT HIP**	**LEFT HIP**
	(Leave blank if stable) ☐ Subluxable ☐ Click ☐ Dislocatable (Barlow positive) ☐ Dislocated – reducible (Ortolani Positive) ☐ Dislocated – not reducible* *can have asymmetrical or reduced hip abduction while in flexion	*(Leave blank if stable)* ☐ Subluxable ☐ Click ☐ Dislocatable (Barlow positive) ☐ Dislocated – reducible (Ortolani Positive) ☐ Dislocated – not reducible* *can have asymmetrical or reduced hip abduction while in flexion

Patient History

Birth History	Gestational age at birth: ____ weeks
	Fetal presentation: ☐cephalic ☐breech ☐ other:
	Birth method: ☐ vaginal ☐ cesarean
	Twin or other multiple: _______
	Other birth complications: ________________
Other	Swaddling: ☐ no ☐yes, duration:
Additional history: ________________	

Examination

Other findings	☐ None ☐ Torticollis ☐ **Clubfoot*** ☐ Flexible foot deformity ☐ Asymmetric skin creases ☐ Galeazzi sign ☐Other: ____________ *** For clubfoot, please make a separate referral to Orthopaedics**

Diagnostic Testing

Has any imaging been ordered No ☐

Yes ☐ Details ________________________/Attach Report

Referring Practitioner ________________________