

# HIP DYSPLASIA REFERRAL

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## CHILD'S DETAILS

Name .....

Date of Birth ..... Gender  Female  Male

Parent/Guardian .....

Address .....

.....

Phone ..... Mobile .....

Email .....

## RISK FACTORS

Family history  Breech presentation  Packaging deformity  Multiple pregnancy  No risk factors

### CLINICAL FINDINGS

Left Right

Positive Barlow sign

Positive Ortolani sign

Limited abduction in flexion

Hip dislocation (Clicky hip)

Leg length shortening

Asymmetric thigh fold (*tick if present*)

Asymmetric gluteal fold (*tick if present*)

Other: .....

Please attach any relevant reports

### REFERRING DOCTOR DETAILS

Referring Dr .....

Provider No. ....

Address .....

.....

Signature .....

**St Vincent's Kids Hip Dysplasia & Sports Injury Clinic**  
Suite 47, Level 4, 141 Grey Street East Melbourne VIC 3002

**Enquiries: PHONE** (03) 9322 3330  
**Referrals: FAX** (03) 9329 4969