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| **ULTRASOUND REFERRAL FOR SUSPECTED INFANT DEVELOPMENTAL DYSPLASIS OF THE HIP (DDH)**  http://hsenet.hse.ie/Hospital_Staff_Hub/ulh/branding/emailsignaturelogo.jpg  **Radiology Department, UL Hospitals, NENAGH, CO. TIPPERARY 067 42342** |

*Eligibility criteria is between* ***4 weeks to 12 weeks of age (maximum)***

*Ultrasound is less useful after 12 weeks of age. Confirmation if required after 12 weeks is by Pelvis X-ray.*

**INFANT MUST HAVE ONE OR MORE POSITIVE RISK FACTORS TO BE ELIGIBLE FOR SCREENING**

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| Does the patient have a **first degree relative** with DDH? (i.e. Parent/Sibling only) | YES No | State relationship: |
| Was the patient breech **AT OR AFTER** 36 weeks gestation?  *Note: In multiple births all babies should be screened if any one of the babies was in a breech presentation.* | YES No | Detail: |
| Is the **clinical hip examination abnormal**?  *Please note Asymmetric creases are not within the inclusion criteria of the national screening programme.* | YES No | Detail of abnormality: |
| The option of requesting a Pelvis x-ray across all UHLG sites remains available for babies that fall outside the inclusion criteria for the DDH National selective ultrasound screening programme if clinically concerned. Pelvis x-ray is typically performed at 6 months of age. | | |

INCOMPLETELY FILLED FORMS WILL BE REJECTED AND RETURNED TO REFERRER

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| |  |  |  | | --- | --- | --- | | Was this patient term at birth?  *If no, please state how many weeks premature.* | YES No | Detail: *Infants born at or before 36 weeks will be date adjusted* |   **Infant Surname:** Click or tap here to enter text. **Gender: Female** Male    **Infant Forename:** Click or tap here to enter text. **D.O.B:** Click or tap to enter a date.  **Mothers Name:** Click or tap here to enter text. **Mothers D.O.B:** Click or tap to enter a date.  **Address:** Click or tap here to enter multiple lines of text.  **Parent Contact Phone No:** Click or tap here to enter text.  ***It is imperative that the contact details are correct as the optimal time to scan these infants is at 6 weeks old.*** |

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| **Medical practitioner signature:** Click or tap here to enter text. **IMC No:** Click or tap here to enter text.  **Print name:** Click or tap here to enter text. **Date:** Click or tap to enter a date. |