**External Cephalic Version (ECV) Referral**

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| Woman's telephone: Home ( ) Mobile:  |

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| **EDD** by LMP ………. /………. /………. [ ]  Certain by USS (earliest) @ …..../ 40: ….…../….…../….….. | Gravida: | Parity: | Blood group: |

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| **SUITABILITY FOR PAPER TRIAGE** [ ]  Yes [ ]  No[ ]  Healthy woman ≥36 weeks (Nulliparous)[ ]  BMI less than 35 | **LMC DETAILS**LMC name: Contact details: …………………………………………………………………………………………………………………………………………………………… |
| **TO ACCOMPANY ALL REFERRALS**[ ]  Growth USS to confirm breech**Maternity Booking Form**[ ]  Accompanies referral [ ]  Already submitted |
| **Contra-indications to ECV Referral – see ECV Guideline** |
| **Absolute**[ ]  Caesaren delivery is required[ ]  Major uterine anomaly[ ]  Ruptured membranes[ ]  Multiple pregnancy[ ]  Abnormal CTG | **Relative**[ ]  Small for gestational-age fetus[ ]  Pre-eclampsia[ ]  Oligohydramnios[ ]  Major fetal anomalies[ ]  Previous C/Section or uterine surgery[ ]  Antepartum haemorrhage within last 7 days |
| **For antenatal clinic review** | **For obstetric review** |
| Other information:        Referred by: Signature:  |

|  |  |
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| **CWH USE ONLY****[ ]** ECV booked Date: ……../……../…….. Time: 1300hrs**[ ]** LMC informed of ECV date**[ ]** LMC to inform woman | **PAPER CLINIC**Meets criteria: [ ]  Yes [ ]  No  *If no, fax form to MOPD, 85301 as obstetric review required*MW signature: Date: ……../………/…….. |

**Suitable for paper triage:** [ ]  **Yes** – **FAX to MOPD (03) 364 4301**