**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**