

I dentify	Patient name: (Affix patient's ID label here) ADDRESS: DOB: M / F	Is an interpreter required Y <input type="checkbox"/> N <input type="checkbox"/> Language spoken at home _____
	Referring clinician detail or hospital providing treatment* Name of the booking hospital*: Clinician name* Provider number* Contact page / extension / mobile* Copy of results to:	
S ituation	Clinical details/Indication* EDD* Blood group* (If Rh-negative, last Anti-D given on/...../.....) Allergies* Has an ECV been attempted previously*? <input type="checkbox"/> Yes. Date/s <input type="checkbox"/> No.	
	Past obstetric/medical history	
A ssessment	Provisional Diagnosis	
	Examination requested – External Cephalic Version <p style="font-size: small; color: #003366;"> Disclaimer: In the event of an emergency, and the patient is not booked at Monash Health/Jessie McPherson, I accept that this patient will become a public patient at Monash Health which may include a caesarean section. </p>	
R equest	Signature* Date*	
	* Each section with an asterisk <u>must</u> be completed and legible. See over page for more details.	

OFFICE USE ONLY	
Date request first used:	Date request expires:

Your doctor has recommended that you use the Fetal Surveillance Unit. You may choose another provider but please discuss this with your doctor first.

Guidelines for requesting an External Cephalic Version

(ECV) in the Fetal Surveillance Unit

For any woman who is booked to give birth outside of a Monash Health or Jessie McPherson Private Hospital, please follow the steps below to request an ECV.

1. Call the Fetal Surveillance Unit at MMC Clayton on 9594 5275 to book an appointment.
2. Add your contact number to the request form, then fax it to the unit on: 9594 5645.
3. If there is any missing information on the request form the clerical staff will contact you. See below for details on the information required.

Information required on the request form

1. Name of the booking hospital or name of the requesting clinician with their provider number
2. Contact phone number of the requesting clinician
3. EDD
4. Blood group
5. Allergies
6. Whether the patient has had a previous ECV this pregnancy and the respective dates
7. Signature of requesting clinician
8. Date