|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Please only use a black or blue pen and print letters when completing this form.* | | | | | | | | | | | | | | | | | | | | | |
| **For office use only:** | | | | | | | | | | | | | | | | | | | | | |
| Date received: | | | |  | | | | | | Case code: | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Section 1: Assisted reproductive treatment provider** | | | | | | | | | | | | | | | | | | | | | |
|  | Adora Fertility | | | |  | Ballarat IVF | | |  | City Babies | | |  | | City Fertility Centre | | | |  | | Genea Melbourne |
|  | Melbourne IVF | | | |  | Monash IVF | | |  | Newlife IVF | | |  | | Number 1 Fertility | | | |  | | Royal Women’s Hospital |
| Other: | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Section 2: Applicant/s** | | | | | | | | | | | | | | | | | | | | | |
| **Applicant 1:** | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | |  | | | Date of birth: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Phone number: | | | |  | | | |
| First name: | | | |  | | | | | | | | | | | | | | | | | |
| Last name: | | | |  | | | | | | | | | | | | | | | | | |
| Email: | | | |  | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | |
| Suburb | | | |  | | | State: | | | | |  | | | | Postcode: | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| *The information provided in this application is true and correct* | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | Signature: | | | |  | | | | | Date: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Applicant 2 (if applicable):** | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | |  | | | Date of birth: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Phone number: | | | |  | | | |
| First name: | | | |  | | | | | | | | | | | | | | | | | |
| Last name: | | | |  | | | | | | | | | | | | | | | | | |
| Email: | | | |  | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | |
| Suburb | | | |  | | | State: | | | | |  | | | | Postcode: | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | |
| *The information provided in this application is true and correct* | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | Signature: | | | |  | | | | | Date: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ |
| **Section 3: Reason for the criteria for treatment not being met** | | | | | | | | | | | | | | | | | | | | | |
| **Which criteria for treatment under section 10 of the *Assisted Reproductive Treatment Act 2008* do you NOT meet?** | | | | | | | | | | | | | | | | | | | | | |
|  | | A doctor is satisfied that a woman is unlikely to become pregnant other than by a treatment procedure or is unlikely to be able to carry a pregnancy or give birth without a treatment procedure. | | | | | | | | | | | | | | | | | | | |
|  | | A woman is at risk of transmitting a genetic abnormality or genetic disease to a child born as a result of a pregnancy conceived other than by a treatment procedure, including a genetic abnormality or genetic disease for which the woman's partner is the carrier. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Details** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |

|  |
| --- |
|  |
| **Completed application forms and attachments may be scanned and emailed to** [**prp@health.vic.gov.au**](mailto:prp@health.vic.gov.au)  **If you do not have access to a scanner or are having difficulty emailing your application form/documents then please contact Panel staff on the above email address.** |
|  |
| **Privacy Statement:** |
| The Patient Review Panel collects personal and health information relating to you as part of its role in considering applications for treatment in accordance with the Assisted Reproductive Treatment Act 2008. Where relevant, this information is handled in compliance with the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001.*  The collection of this information is necessary for the Panel to perform its functions. The Panel’s ability to handle and determine your application may be hindered if you do not disclose/provide all relevant information.  All information provided will only be used for the purposes intended. All information will be treated as confidential unless otherwise required by law.  In some circumstances the Panel may discuss your application with your ART provider or disclose information about you to a third party for the purposes of obtaining an opinion/assessment/information about your application. Where it is intended to disclose information to a third party your consent will be sought.  Outcomes of applications will be recorded and reported on in a de-identified statistical form and a copy of the certified decision provided to your ART provider. If a decision of the Panel may be reasonably expected to have a significant impact on the way in which treatment is carried out in Victoria the Panel must provide the Victorian Assisted Reproductive Treatment Authority with a de-identified copy of the decision (you will be advised where this occurs).  The information the Panel holds about you can be accessed by you upon request to the Associate. |