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| *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: | | | |  | | | | | | | | | | | | | | | | | |
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| **Section 2: Applicant** | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | |
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| **Section 2: Gamete provider (if different to above)** | | | | | | | | | | | | | | | | | | | | | |
| Title: | | |  | | | Date of birth: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | Phone number: | | | | |  | | | | |
| First name: | | |  | | | | | | | | | | | | | | | | | | |
| Last name: | | |  | | | | | | | | | | | | | | | | | | |
| Email: | | |  | | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | |
| Suburb | | |  | | | State: | | | | |  | | | Postcode: | | | | |  | | |
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| **Section 3: Gamete details** | | | | | | | | | | | | | | | | | | | |
| **Gamete type:** | | | | | | | | | | | | | | | | | | | |
|  | Sperm | | | | |  | Eggs | | | | |  | | Ovarian tissue | | | | | |
| **Storage details:** | | | | | | | | | | | | | | | | | | | |
| Clinic unique identifying number | | | |  | | | | | | | | | | | | | | | |
| Amount stored | | |  | | First date of storage | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Date storage expires | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Previous extension details:** | | | | | | | | | | | | | | | | | | | |
| Have you previously been granted an extension of storage by the Patient Review Panel or any other relevant body? | | | | | | | | |  | Yes |  | | No | | Date: | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Section 4: Reason for seeking extension** | | | | | | | | | | | | | | | | | | | |
| Tick all that apply: | | | | | | | | | | | | | | | | | | | |
|  | I intend to use the gametes in an assisted reproductive treatment procedure to have a child. | | | | | | | | | | | | | | | | | | |
|  | I intend to donate the gametes to another person/couple for use in an assisted reproductive treatment procedure to have a child but require more time for this to occur. | | | | | | | | | | | | | | | | | | |
|  | The gametes have already been donated to another person/couple for use in an assisted reproductive treatment procedure to have a child. | | | | | | | | | | | | | | | | | | |
| Details: | |  | | | | | | | | | | | | | | | | | |
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| **Section 5: Exceptional circumstances** | | | | | | | | | | | | | | | | | | | |
| **Application is being made after the expiration of the storage period** | | | | | | | | | | | | | | | | | | | |
| Is this application being made after the expiry of the storage period? | | | | | | | | | | | | | | | |  | Yes |  | No |
| Details: | |  | | | | | | | | | | | | | | | | | |
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| **NOTE - If your application is made after the storage has expired and you do not explain what exceptional circumstances prevented you from making an application before the expiry, then the Panel may not be able to approve your application.** | | | | | | | | | | | | | | | | | | | |
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| **Application is being made without the written consent of one or more of the gamete provider/s** | | | | | |
| Is this application being made without the written consent of one or more of the gamete providers? | |  | Yes |  | No |
| Details: |  | | | | |
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| **NOTE - If you are making this application without the written consent of one or more of the gamete providers and you do not explain what exceptional circumstances have prevented them from providing their written consent to an extension, then the Panel may not be able to approve your application.** | | | | | |
|  | | | | | |
| **Section 6: Extension period sought** | | | | | |
| How many more years/months would you like to keep the gametes in storage? | |  | | | |
| **NOTE - If you do not do not provide a specific requested longer storage period, then the Panel may not be able to approve your application.** | | | | | |

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| **Completed application forms and attachments may be scanned and emailed to** [**prpstorage@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. |