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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: | | | | | |  | | | | | |
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| **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/s** | | | | | | | | | | | | | | | | | | | | |
| **Applicant 1:** | | | | | | | | | | | | | | | | | | | | |
| Title: | | |  | | | Date of birth: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Phone number: | | | |  | | | |
| First name: | | |  | | | | | | | | | | | | | | | | | |
| Last name: | | |  | | | | | | | | | | | | | | | | | |
| Email: | | |  | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | |
| Suburb | | |  | | | State: | | | | |  | | | | Postcode: | | | |  | |
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| *The information provided in this application is true and correct and I understand that the Patient Review Panel will need to contact the relevant assisted reproductive treatment clinic and/or doctor to discuss the reasons for the refusal for treatment and to obtain copies of any relevant files or records and I consent to this occurring.* | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | Signature: | | | |  | | | | | Date: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ |
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| **Applicant 2 (if applicable):** | | | | | | | | | | | | | | | | | | | | |
| Title: | | |  | | | Date of birth: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Phone number: | | | |  | | | |
| First name: | | |  | | | | | | | | | | | | | | | | | |
| Last name: | | |  | | | | | | | | | | | | | | | | | |
| Email: | | |  | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | |
| Suburb | | |  | | | State: | | | | |  | | | | Postcode: | | | |  | |
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| *The information provided in this application is true and correct and I understand that the Patient Review Panel will need to contact the relevant assisted reproductive treatment clinic and/or doctor to discuss the reasons for the refusal for treatment and to obtain copies of any relevant files or records and I consent to this occurring.* | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | Signature: | | | |  | | | | | Date: | | | | \_\_\_/\_\_\_/\_\_\_\_\_\_ |
| **Section 3: Reason for refusal of treatment** | | | | | | | | | | | | | | | | | | | | |
| **Details** | | | | | | | | | | | | | | | | | | | | |
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| **Section 5: Attachments** | | | | | | | | | | | | | | | | | | | | |
| Please attach a copy of the ART provider’s (or the doctor’s) written reasons for refusing to carry out the treatment procedure - this should explain why they reasonably believe that a child that may be born as a result of a treatment procedure carried out would be at risk of abuse or neglect.  **NOTE:** If you have not already been provided with written reasons for the refusal, please contact the ART provider (or doctor) and ask for these to be provided to you, and then attach a copy to this application form. | | | | | | | | | | | | | | | | | | | | |
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| **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.** | | | | | | | | | | | | | | | | | | | | |
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| **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. | | | | | | | | | | | | | | | | | | | | |