IMPORTANT INFORMATION FOR COMPLETING THIS FORM

Use **black or blue ink only** and print within the boxes in BLOCK letters.

Please ensure:

- that email & telephone numbers are provided as the Patient Review Panel may be required to contact you regarding you application at short notice.
- that all relevant sections are completed.
- that all applicants have signed and dated the form in **Section 9** & **10**.
- that you have read and are familiar with the **Privacy Statement** at the bottom of this page.

Please note that failure to comply with any of the above requirements may delay the processing of your application.

Further Information

If you have any questions regarding the completion of this form please contact your Assisted Reproductive Treatment provider in the first instance.

If you have any further questions please contact the Patient Review Panel on (03) 9096 2806 or via email at prp@health.vic.gov.au.

What happens next

Once your application has been received you will be sent a confirmation of receipt by email.

Your application will then be checked for all required information and you will be notified of the next available hearing date that your application can be considered by the Panel and whether your attendance is required.

Once the Panel has made a decision regarding your application, you will be notified within 14 days.

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*. This information is handled in compliance with *the Information Privacy Act 2000* 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.

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PRP The Patient Review Panel

GPO Box 4541
MELBOURNE VIC 3001
P. +61 3 9096 2806
E. prp@health.vic.gov.au

REMOVAL OF EMBRYOS FROM STORAGE APPLICATION FORM

For office use only

Date received D D M M Y Y Case code

Section 1: Application Type

Please circle embryos stored:

Embryos formed without donor gametes **Embryos formed with donor gametes**

Section 2: Facility Where Stored

Ballarat IVF **City Babies** **City Fertility Centre** **Melbourne IVF** **Monash IVF** **Royal Women's Hospital Andrology**

Other:

Section 3: Storage Details

Facility where first placed in storage

Patient unique identifying number

Amount stored

Date first placed in storage D D M M Y Y

Date when current storage expires D D M M Y Y

Section 4: Reason/s for removal of embryos for storage

Please provide reasons and background as to why removal of embryos from storage is being sought. If one of the gamete providers has not been or is not able to be contacted please detail any and all efforts to make contact and provide supporting documentation.

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Section 5: Gamete Provider 1 Details

Date of Birth D D M M Y Y Title

First name

Last name

Postal address

Suburb

State Postcode

Phone number

Email address

Section 6: Gamete Provider 2 Details (if applicable)

Date of Birth D D M M Y Y Title

First name

Last name

Postal address

Suburb

State Postcode

Phone number

Email address

Section 7: Donor 1 Details (if applicable)

– ART Provider to complete –

Please circle type of gametes/embryos donated

Sperm donated **Oocyte/s donated** **Embryo/s donated**

Unique identifier

Is donor a clinic recruited donor or known to the applicants?

Clinic recruited **Known to applicants**

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Section 8: Donor 2 Details (if applicable)

– ART Provider to complete –

Please circle type of gametes/embryos donated:

Sperm donated **Oocyte/s donated** **Embryo/s donated**

Unique identifier

Is donor a clinic recruited donor or known to the applicants?

Clinic recruited **Known to applicants**

Section 9: Gamete Provider 1 Signature

The information provided on this application is true and correct

Signature _____ Date D D M M Y Y

Section 10: Gamete Provider 2 Partner Signature

The information provided on this application is true and correct

Signature _____ Date D D M M Y Y

Completed forms can be:

- Scanned and emailed to prp@health.vic.gov.au
- Mailed to:

  Patient Review Panel
  GPO Box 4541
  MELBOURNE VIC 3001