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SEX SELECTION APPLICATION FORM

For office use only			
Date received	D D M M Y Y	Case code	PGD

Section 28 of the Assisted Reproductive Treatment Act 2008 prohibits sex selection in Victoria, except in two situations:

- a) where it is necessary for the child to be of a particular sex so as to avoid the risk of transmission of a genetic abnormality or a genetic disease to the child; or
- b) the Patient Review Panel has otherwise approved the use of the gametes or embryo for the purpose or a purpose

of producing or attempting to produce a child of a particular sex.																				
Section 1: Applicant's Details																				
Date of Birth	D	D	M	M	Υ	Y				Title	е									
First name																				
Last name									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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State		<u> </u>			<u></u>	ļ							Pos	stcode	9	Y			<u></u>	
Phone number		<u> </u>				7														
Email address																				
		<u> </u>	<u> </u>																	
Section 2: Applicant'	s Pa	rtner	Deta	ails (if apı	plica	ble)									·	·	·	¥	,
Date of Birth	D	D	M	M	Υ	Υ		·		Title	e	·	·							
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section 3: Assisted Reproductive Treatment Clinic

Please circle the clinic where you are seeking treatment:

Newlife **Ballarat** City Number 1 Adora City Genea Melbourne Monash **IVF** Fertility **IVF Fertility Babies** Melbourne **IVF** IVF **Fertility** Centre

Section 4:	What sex are you seeking to select for?	
	Male	Female
Section 5:	Do you have any existing children from your cu	rrent or a previous relationship?
If yes, plea	Yes se list the name, sex and age of each child:	No
Section 6:	Are you seeking sex selection to reduce the ris condition?	k of transmission of a genetic or medica
lf yes, plea	Yes se continue to Section 7 of the application form.	No
If no, pleas	se continue to Section 13 of the application form.	
Section 7:	What is the condition/s that you are seeking to	reduce the risk of transmission of?
Section 8:	Does anyone in your family already have this co	ondition? If so, who?
	the name, sex, age and relationship you have with ea	
Section 9:	What is the impact of this condition on the affect	cted person/people?

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Section 11: What n	ersonal or profession	al supports do vou hay	ve/receive for this condition?	?
or example, menus	, family, treating clinicia	ins of ND15 lunding.		
ection 12: As sex	selection can only rec	duce the risk of transm	ission (not eliminate it), wha	at would
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ection 12: As sex	selection can only rec	duce the risk of transm	ission (not eliminate it), wha	at would
ection 12: As sex	selection can only recould your family cope	duce the risk of transm if you were to have and	ission (not eliminate it), wha	ondition?
Section 12: As sex ou do and how wo	selection can only recould your family cope	duce the risk of transm if you were to have and	ission (not eliminate it), wha other child affected by this c	ondition?
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ONLY TO BE COMPLETED IF APPLICANTS ARE SEEK THAN TO REDUCE THE RISK OF TRANSMISSION		
Section 13: Why are you seeking sex selection?		
Section 14: Applicant's Signature		
Section 14. Applicant's Signature		
The information provided on this application is true and	l correct	
Signature		
	Date	D D M M Y Y
Section 15: Applicant's Partner Signature		
The information provided on this application is true and	d correct	
Signature	Date	D D M M Y Y
Section 16: Attachments		
Have you attached the following documents:		processions.
Letter from a genetic counsellor or a clinical geneticis sex selection.	t recommending	
Information about family genetic history (where relevant	ant)	
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Evidence of relevant diagnosis		
Any genetic screening reports for applicants or existing	ng children.	
Completed forms can be:		
 Scanned and emailed to prp@dhhs.vic.gov.au Mailed to: 		

Patient Review Panel GPO Box 4541 MELBOURNE VIC 3001

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 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).