Patient Review Panel

Application – Sex selection

Clinic

☐ Adora Fertility	☐ Ballarat IVF	☐ City Babies	☐ City Fertility Centre	☐ Create Fertility
☐ Genea	☐ Life Fertility Centre	☐ Melbourne IVF	☐ Monash IVF	☐ Newlife IVF
☐ No. 1 Fertility	☐ Public Fertility Service	☐ Thrive Fertility	☐ The Royal Women's Hospital	
☐ Other:				

Applicant details

Postal address:

Suburb: State: Postcode:

Applicant 1

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx

☐ Other:

First name:

Last name:

Date of birth:

Email address:

Phone number:

The information provided in this application is true and correct

Signature:

Date:

Applicant 2 (*if applicable*)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx

☐ Other:

First name:

Last name:

Date of birth:

Email address:

Phone number:

The information provided in this application is true and correct

Signature:

Date:

Sex selection details

Which sex do you want to select for? ☐ Female ☐ Male

Why do you want to select the sex of a future child?

☐ To reduce the risk of transmission of a genetic condition to a future child

☐ Other (provide details below):

Reduction of risk of transmission of a genetic condition

What is the condition?	

Who in your family is affected by this condition?

Name:	Age:	Relation:
Name:	Age:	Relation:
Name:	Age:	Relation:
Name:	Age:	Relation:

Do you have any children not already listed above? ☐ YES ☐ NO

If YES, please provide details below:

Name:	Age:	Relation:
Name:	Age:	Relation:
Name:	Age:	Relation:

Describe the impact of this condition on the affected members of your family:

Describe the impact of the condition on the other (non-affected) members of your family, including yourselves.

If you already have a child with this condition, how might that affect a future child who does not have the condition and how would you reduce any negative effects on the future child?

Reduction of risk of transmission of a genetic condition (cont.)

As sex selection can only reduce, not eliminate, the risk of transmission of this condition, what impact would it have on you and your family if you were to have another child affected by this condition?

Do you receive NDIS or other professional support for this condition? *If YES, please provide details below:*	☐ YES	☐ NO

Do you require assisted reproductive treatment for a reason other than sex selection (for example, infertility)?	☐ YES	☐ NO
Have embryos already been formed?	☐ YES	☐ NO

Attachments – *These documents assist the Panel and may be asked for, if not provided.*

☐ Letter/report from genetic counsellor and/or clinical geneticist supporting sex selection

☐ Letter from IVF doctor supporting treatment and sex selection

☐ Information about family history of the condition

☐ Evidence of diagnosis of the condition

☐ Results of genetic testing relating to the condition

When to use this form

Use this form to make an application to the Patient Review Panel (the Panel) for approval to select the sex of a future child.

Returning this form

If you do not have all the information/documents required to complete your application (such as medical letters or reports), then you will need to contact your clinic or other relevant medical professionals to get the information/documents. The Patient Review Panel is an independent body so does not have access to your patient information.

If there is missing or incorrect information or documents then Panel staff will contact you and/or your clinic to request that it be provided/amended.

Completed applications forms should be emailed to prp@health.vic.gov.au. It is important that applicant has signed and dated the form.

Additional information

Generally all applicants will be requested to attend a hearing (via videoconference) with the Panel. If you are not required to attend a hearing, Panel staff will let you know.

Outcome

You will be sent a certificate stating the decision of the Panel via email and a copy will also be sent to your clinic. At a later date, you will also receive written reasons for the Panel's decision.

Privacy Statement

The Panel collects personal and health information relating to you in accordance with its functions under the *Assisted Reproductive Treatment Act 2008* (the ART Act) and, where required, this information is handled in compliance with the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001*.

The Panel's ability to consider your application may be hindered if you do not provide all relevant information and it is an offence under the ART Act to knowingly or recklessly give false or misleading information or omit to give material information to the Panel. All information provided will only be used for the purposes intended and will be treated as confidential unless otherwise required by law.

The Panel may seek additional or clarifying information from your clinic to assist in the processing of your application and by submitting this form, you consent to this occurring.

Outcomes of applications are recorded and reported in a de-identified statistical form. If a decision of the Panel may be reasonably expected to have a significant impact on the way ART is carried out in Victoria then the Panel must provide the Secretary of the Department of Health with a de-identified copy of the decision. You will be advised if this occurs.

The information the Panel holds about you can be accessed by you upon request to the Associate of the Panel by emailing prp@health.vic.gov.au.