

SEX SELECTION APPLICATION FORM

For office use only										
Date received	D	D	M	M	Y	Y	Case code	P	G	D

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	Y	Y	Title				
First name											
Last name											
Postal address											
Suburb											
State							Postcode				
Phone number											
Email address											

Section 2: Applicant's Partner 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 3: Assisted Reproductive Treatment Clinic

Please circle the clinic where you are seeking treatment:

Adora Fertility	Ballarat IVF	City Babies	City Fertility Centre	Genea Melbourne	Melbourne IVF	Monash IVF	Newlife IVF	Number 1 Fertility
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ONLY TO BE COMPLETED IF APPLICANTS ARE SEEKING SEX SELECTION FOR A REASON OTHER THAN TO REDUCE THE RISK OF TRANSMISSION OF A GENETIC OR MEDICAL CONDITION

Section 13: Why are you seeking sex selection?

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Section 14: Applicant's Signature

The information provided on this application is true and correct

Signature

Date

D	D	M	M	Y	Y
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Section 15: Applicant's Partner Signature

The information provided on this application is true and correct

Signature

Date

D	D	M	M	Y	Y
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Section 16: Attachments

Have you attached the following documents:

Letter from a genetic counsellor or a clinical geneticist recommending sex selection.

Information about family genetic history (where relevant)

Evidence of relevant diagnosis

Any genetic screening reports for applicants or existing 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).

The information the Panel holds about you can be accessed by you upon request to the Associate.