



MR1088



the women's
the royal women's hospital

Reproductive Services

Import or Export of Frozen Gametes and Embryos Consent Form

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PATIENT LABEL)

This form must be completed prior to the commencement of treatment. It remains valid for one year after signing. It is signed in conjunction with the relevant procedural consent form.

Attach patient labels – Patient & Partner (if applicable) to confirm details on the labels are correct.

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PARTNER LABEL)

Patient Name:			
Patient DOB:			
Telephone No.:		Mobile No.:	
Email Address:			
Partner Name: (If applicable)			
Partner DOB:			
Telephone No.:		Mobile No.:	
Email Address:			
Address:			
	State:		Postcode:

Details of Cryostored (Frozen) Items to be Transported

(Circle option)	Importation / Exportation		
Biological Items	Number to Transport		
	<i>*please either circle "ALL" or indicate the quantity to be transported</i>		
Embryos	ALL	Specific Quantity:	
Semen	ALL	Specific Quantity:	
Eggs	ALL	Specific Quantity:	
Ovarian Tissue	ALL	Specific Quantity:	
Donated Gametes / Embryos	ALL	Specific Quantity:	

If a specific quantity has been selected please specify the exact items you are wanting to be transported

July
2023

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(AFFIX PARTNER LABEL)

Details of Transportation

Sending Clinic Name:			
Contact Person Name:			
Telephone No.:		Mobile No.:	
Email Address:			
Address:			
	State:		Postcode:
Receiving Clinic Name:			
Contact Person Name:			
Telephone No.:		Mobile No.:	
Email Address:			
Address:			
	State:		Postcode:



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Acknowledgement

I/we acknowledge –

- There are risks associated with the transportation of cryopreserved material which are outside the control of either the sending or receiving fertility clinic
- Approval for the import or export of gametes and embryos from donated biological material is required from Victorian Assisted Reproductive Treatment Authority (VARTA) before transportation may be undertaken. Approval will be obtained if relevant
- That the viability of the cryopreserved material might be compromised if adverse events are encountered during the transport process
- The Women's Reproductive Service is not responsible or liable for the integrity or viability of cryopreserved material whilst in transit between clinics
- The carrier tasked with the transportation is not responsible or liable for the integrity or viability of the cryopreserved material upon arrival at its destination
- The Women's Reproductive Service staff have provided information on qualified courier services
- The intended purpose of gametes and/or embryos is a transfer into a woman's uterus
- The intended purpose is not commercial surrogacy
- There are costs associated with the transportation which have been explained to me by The Women's Reproductive Service staff and that I/we are responsible for these expenses

I/we acknowledge –	Agree	Disagree
I/we would like to be notified by letter/email/phone once the embryos/semen/eggs/ ovarian tissue has been transported		



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Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PARTNER LABEL)

Consent (select one)

I/we agree to the removal of the following cryostored biological items from storage at the Reproductive Service Unit at The Royal Women's Hospital Victoria and transported by a commercial carrier service to the nominated receiving fertility clinic (**EXPORT**)

OR (select one)

I/we agree to the transfer of the following cryostored biological items from storage and transported by a commercial carrier service to the Reproductive Service Unit at The Royal Women's Hospital Victoria (**IMPORT**)

Section 38 of the *Assisted Reproductive Treatment Act 2008* makes it an offence to knowingly or recklessly give false or misleading information or omit to give material information on this consent form.

Patient's Signature		Partner's Signature	
Patient's Name		Partner's Name <i>If applicable</i>	
Date Signed		Date Signed	

Use of an Interpreter

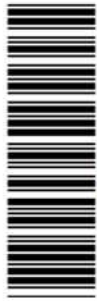
This consent was completed with the use of a Healthcare Interpreter service.

I declare that I have interpreted the dialogue between the person/couple and the health practitioner as accurately and completely as possible and I believe the person/couple understood all relevant information.

Language Translated			
Interpreter's Name			
Interpreter's Signature			
Interpreter Provider (<i>if not The Women's</i>)		Date of service	

Video-Conferencing

This consent was completed using video-conferencing technology.



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Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PARTNER LABEL)

Office Use Only

Details	Yes	No	Other	Staff Member Name
				Signature
Time in storage	No. of Years		Date of Freezing	
Embryos				
Sperm				
Eggs				
Ovarian tissue				
Donor Gametes/Embryos				
VARTA Approval obtained (Donor only)			Date of Approval	/ /20
Admin. Confirmation – All storage fees paid in full			Amount Outstanding	
Patient contacted to confirm request to transport			Date Contacted	
Partner contacted to confirm request to transport (If applicable)			Date Contacted	
Acceptance of Import/Export Consent following confirmation			Date Accepted	
Confirmation of Items in Storage (If applicable)			Date Confirmed	
Items have been removed from cryostorage – Embryologist confirmed details with consent form and storage records			Date of Discard	

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Office Use Only continued

Details	Yes	No	Other	Staff Member Name
				Signature
Witness confirmed details with consent form and storage records			<i>Date of Witnessing</i>	
Patient contacted as per request			<i>Date Patient Contacted</i>	
Cryostorage records updated to reflect transportation			<i>Date Cryostorage Records Updated</i>	