Department of Andrology & Sperm Bank
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ID#
Type:

SEMEN STORAGE REQUEST & CONSENT FOR A MINOR

For name/address change and cancellations please contact andrology data manager
Email: andrology.datamanager@thewomens.org.au
For all other matters contact general email: andrology@rch.org.au

Patient (Male)

Surname

First Name

Preferred Name

Pronouns HE/HIM | SHE/HER | OTHER

Date of Birth D D M M Y Y Y Y

Postal address

Suburb

State Postcode

Phone (mob)

Email

Medicare number Reference number

Medicare expiry D D M M Y Y Y Y

Your doctor's name: _____ Ph:_____

Next of Kin Details (Father/Mother/Brother/Sister/Other_____) Please circle

Surname/Family Name: _____First name_____

Preferred Name: _____

Address: _____

Postcode_____

Date of birth _____/_____/_____

Telephone Home: _____

Work: _____

Mobile: _____

Email_____

1. Request for Semen Storage

I REQUEST the Andrology Unit to store my/my child's/ (if other write relationship with the minor _____) semen (hereinafter referred to as sperm). I make this request for the following reasons (please tick appropriate box):

☐ Pre-Vasectomy ☐ Pre-Chemotherapy ☐ Chronic Viral Illness

☐ HRT (hormone replacement therapy)

☐ Other _____*(please specify)*

2. Period of Storage (**for further information: www.varta.org.au**)

I understand that under the *Assisted Reproductive Treatment Act 2008 (Vic)* (ART Act), sperm can only be stored for up to ten (10) years from the date it was first frozen except in the following circumstances:

(a) 20 years if sperm has been obtained from a minor AND a doctor has certified that there is a reasonable risk that the minor may become infertile before reaching adulthood;

(b) permission is given by the Patient Review Panel (PRP) for an extension of the storage period. The PRP is an independent body established under the ART Act; or

(c) in specific circumstances as set out in the ART Act.

I understand that without a valid extension permit, the Andrology Unit, of the Royal Women's Hospital and Children's Pathology Service (hereafter to be referred to as "the Andrology Unit") is legally obliged to stop storing my/my child's sperm specimen as soon as ten (10) years have passed, unless

(a) a doctor has certified there is a reasonable risk that the minor may become infertile before reaching adulthood; or

(b) where the PRP has granted an extension or in the specific circumstances in the Act.

3. Fees and Notices

I agree that The Royal Women's Hospital will be paid any and all fees related to freezing and storing my/my child's sperm. I have been advised of these fees and understand these may change in future.

4. Cancellation of Sperm Storage

I understand that I can cancel my/my child's sperm storage at any time by directly contacting the Andrology Unit and undergoing a cancellation process.

I authorise the Andrology Unit to remove my/my child's sperm from storage and discard it without direct contact from myself, if:

- The Royal Women's Hospital fees for storing this sperm have not been paid in full after all reasonable attempts have been made by the Andrology Unit to contact me and I am considered to be 'non-contactable' as a result; or

- Ten years (or such other period as allowed under the ART Act) have passed since the sperm was first frozen and a Doctor has not certified that there is a reasonable risk that my/my child may become infertile before reaching adulthood;

- In the event of my child's death while still a minor.

I acknowledge that the Andrology Unit follows a specific patient notification procedure which consists of a number of attempts to contact me by written communication and by telephone. If after all reasonable attempts to contact me have failed, I understand that the Andrology Unit will determine that that I am non-contactable and discard my/my child's sperm.

5. Instructions in the Event of My/My Child's Death

The posthumous use of stored sperm is governed by Section 5 of the ART Act. Please visit the website of the Victorian Assisted Reproductive Treatment Authority (VARTA) for further information: www.varta.org.au

In the event of my/my child's passing at 18 years of age or older, my/my child's sperm may be used following their death by their partner if permission is granted by the PRP for approval to use the sperm posthumously.

I understand that under the ART Act, I am not able to donate my/my child's sperm to any person.

6. Use of Personal Health Information

I understand that the Royal Children's Hospital and the Royal Women's Hospital are bound by the requirements of applicable Privacy laws with respect to the management of patient health information.

I understand that my personal health information may be used to provide statistical data for licensing and regulatory requirements, research or quality assurance purposes. Information used for these purposes will be de-identified and not identify me by name or inference.

7. Certification for storage up to 20 years

In the case of a request for storage up to 20 years, a requirement of the **ART** Act is that the minor storing the sperm has a reasonable risk of infertility before becoming an adult. Storage for 20 years is not automatic without valid written certification (**see Clause 2 above**).

8. Liability waivers

By signing this Request for Sperm Storage, I acknowledge that:

- The Royal Children's Hospital and the Royal Women's Hospital, their employees, servants and agents will not be liable in respect of any loss or damage to my/my child's sperm during the entire period of storage, including transport to and from other sites and temporary storage at other sites.

- The Royal Children's Hospital and The Royal Women's Hospital do not guarantee that my/my child's sperm will produce a pregnancy after storage.

9. Acknowledgments

By signing this Request for Sperm Storage:

- I confirm that the personal details I have provided for my/my child are correct.

- I confirm that the contact details I have provided are correct.

- I acknowledge that it is my sole responsibility to ensure that the Andrology Unit has my correct contact details and to notify the Andrology Unit in writing of any change of address or other contact details as soon as possible.

- I understand that in the event that I am not able to be contacted at the address I have provided, the Andrology Unit will cancel my/my child's storage and discard the sperm without further notice to me.

- I acknowledge that I am responsible for paying storage fees and understand that if the storage fees are not paid in full, the Andrology Unit will cancel my/my child's storage and discard the sperm without further notice to me.

- I understand that it is my sole responsibility to apply to the PRP for permission to extend my sperm storage beyond the statutory 10 year expiry date and failing to do before the storage term expires will result in my sperm being discarded.

- I understand that once removed from storage and discarded, the sperm will no longer be available to my/ my child for any purpose.

Note: Was the storage consent read to you by andrology staff to meet any special needs? *Yes* ☐ *No* ☐

*Signature: _____

*Name (please print) _____

(Signature and name of Patient/Parent/Guardian as mentioned above are required)

Date: _____/_____/_____

In the presence of:

Signature of witness _____

Name of witness (please print) _____

Date: _____/_____/_____

Has a doctor's written certification been obtained (if 20 years storage applicable):

☐ Yes ☐ No

If no certification is obtained the maximum initial storage period is 10 years