FertilityNorth
Fertility & Endometriosis Treatment Centre
GynaeNorth

CLERICAL INFORMATION

TREATING PATIENT

*Mandatory field

Please ensure that your name on this form **MATCHES** the name stated on your Medicare card

TITLE	
*SURNAME AS WRITTEN ON YOUR MEDICARE CARD	
*GIVEN NAME(S) AS WRITTEN ON YOUR MEDICARE CARD	
PREFERRED NAME(S) (IF APPLICABLE)	
PREVIOUS SURNAME (IF APPLICABLE)	
*SEX ASSIGNED AT BIRTH	
GENDER (FEMALE, MALE, NON-BINARY, TRANSGENDER, OTHER)	
PREFERRED PRONOUNS (SHE/HER, HE/HIM, THEY/THEM, OTHER)	
*DATE OF BIRTH	
*PLACE OF BIRTH OR COUNTRY (IF OUTSIDE AUSTRALIA)	
*STREET ADDRESS	
*SUBURB & POST CODE	
*MOBILE NUMBER	
*EMAIL ADDRESS	
*OCCUPATION	
*ARE YOU FIFO / DIDO?	☐ Yes ☐ No
*HOW DID YOU HEAR ABOUT US?	☐ GP ☐ Specialist ☐ Friend/Family ☐ Website ☐ Social Media ☐ Other
*HAVE YOU HAD IVF BEFORE?	☐ Yes ☐ No — IF YES, NAME OF CLINIC(S):

MEDICARE NUMBER			☐ NA
MEDICARE REFERENCE #		EXPIRY:	
PRIVATE HEALTH INSURANCE HOSPITAL COVER ONLY ANCILLARY/EXTRAS COVER N/A	FUND NAME:		☐ NA
	MEMBERSHIP NUMBER:		
HAVE YOU HAD THIS COVER FOR 12+ MONTHS?	☐ Yes	☐ No, I joined in: _____	

HAVE YOU BEEN HOSPITALISED OUTSIDE OF WA IN THE LAST 12 MONTHS?	☐ Yes	☐ No
IF YES, NASAL SWAB?	☐ Positive	☐ Negative

REFERRING DR NAME		REFERRAL DATE	
REFERRING DR ADDRESS			
GP NAME AND ADDRESS (IF DIFFERENT FROM REFERRING DR)			

MEDICAL INFORMATION

Treating Patient Details	
Name	
Date of Birth	
Street Address	
Suburb	
Patient Initials	

Height (cm)		Weight (kg)		BMI	
Ethnicity					
Occupation					

PART I – OBSTETRIC / GYNAECOLOGICAL HISTORY

MENSTRUAL HISTORY			
Age of first ever period		Date of first day of last period	

IN THE LAST 6 MONTHS					
Average number of days from 1st day of period to the 1st day of next period					
Average number of days of bleeding					
Flow	☐Light ☐ "Normal" ☐Heavy		Pain	☐ Mild-None ☐ Moderate ☐ Severe	
Do you have bleeding between periods?	☐Yes ☐No	Describe			

CONTRACEPTION		
Type(s) of Contraception used in the past	Approximate Start Date	Approximate Date of Last Use
1.		
2.		
3.		

INTERCOURSE ☐ N/A			
Is Intercourse painful? (circle)	☐Yes ☐No	Describe	

PREVIOUS GYNAECOLOGICAL SURGERY ☐ N/A			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

MEDICAL INFORMATION

Have you ever been diagnosed with an STI?	☐Yes ☐No	Describe	
Date of last pap smear / cervical screening test (CST):		Result?	
Have you ever had any abnormal pap / CST results?	☐Yes ☐No	Describe	

PREGNANCIES ☐ N/A				
Pregnancies	Date of Completion	Outcome*	Duration (w)	Previous Partner
1st				☐Yes ☐No
2nd				☐Yes ☐No
3rd				☐Yes ☐No
4th				☐Yes ☐No
5th				☐Yes ☐No

* V= Vaginal birth, C/S=Caesarean birth, M1= Complete Miscarriage, M2= Miscarriage needing curette, E= Ectopic pregnancy, T= Termination of pregnancy

PART II – MEDICAL & FAMILY HISTORY

MEDICINES			
Allergies to Medicines	Prescribed Medications	Condition Treated	
1.	1.	1.	
2.	2.	2.	
3.	3.	3.	
4.	4.	4.	
Do you use complementary medicines?	☐Yes ☐No	Describe	

List any medical problems you have EVER had in your ENTIRE life to date (not already mentioned)			
Condition	Treatment	Resolved (Yes / No)	Date (month/year)
1.			
2.			
3.			
4.			

OPERATION(S)			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

List any diseases or genetic conditions that have affected your family **E.g.** diabetes, endometriosis, gynaecological cancer, blood disorder, spina bifida, congenital heart disease			
Condition	Who is affected	Age at onset	Date (month/year)
1.			
2.			
3.			
4.			

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MEDICAL INFORMATION

PART III - INFERTILITY HISTORY

Have you experienced any of the following? (tick all that apply)			
Irregular/ Infrequent Periods	☐	Milky breast discharge	☐
Excessive / Abnormal hair growth	☐	Poor sense of smell	☐
Bad skin/ acne	☐	Visual disturbance	☐

Have you ever been investigated or treated for Infertility?	No ☐ *(please move on to Part IV)* Yes ☐ *(please complete sections below)*

PREVIOUS CLINIC(S)

Clinic Name	Date first seen	Date last seen	Specialist name
1.			
2.			
3.			

PREVIOUS TREATMENT CYCLE(S) ***(Please bring any results / reports you have to your consultation and complete details below)***

Type of Cycle	Outcome	Clinic Name	Date
1.			
2.			
3.			
4.			
5.			

PART IV – LIFESTYLE

HOW MUCH DO YOU?	
Smoke? (per day)	
Drink Coffee? (cups per day)	
Drink Alcohol (drinks per week)	
Exercise? (times per week)	
Take Vitamin Supplements? (times per week)	
Use Non-prescription drugs?	☐ Yes ☐ No

Is there anything else not covered that you feel may be relevant?

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FNC1 PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

References: Human Reproduction Technology Act (HRT Act) 1991, as amended by the Acts Amendment (Lesbian and Gay Law Reform) Act 2002 and the Human Reproduction Technology Amendment Act 2004, Privacy Act 1988 (Cth) and current RTAC Code of Practice

I / We,

Patient Details	Partner Details
Given Name:	
Surname:	
Date of Birth:	
Street Address:	N/A
Suburb & Postcode:	
Patient Initial……	Partner Initial……

acknowledge that The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose the patient's personal information.

1. RATIONALE AND SOURCES FOR COLLECTION OF INFORMATION

1. We will collect information that is necessary to properly advise and treat you. Necessary information may include full medical history, family medical history, ethnicity, contact details, Medicare / private health fund details, genetic information, pathology results and billing/account details.
2. The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example, other medical practitioners, such as former GPs and specialists, other health care providers, such as pathologists, physiotherapists, occupation therapists, psychologists, pharmacists, dentists, nurses and hospitals and Day Surgery Units.
3. Fertility North staff and medical practitioners may participate in the collection of this information. All Fertility North staff are required to sign a confidentiality agreement as part of their conditions of employment.
4. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

2. USE AND DISCLOSURE REQUIREMENTS OF COLLECTED INFORMATION

By signing this document, you are giving consent for Fertility North staff to use and disclose your information for purposes such as:

1. Account keeping and billing purposes;
2. Referral to another medical practitioner or health care provider;
3. Updating your referring doctor with test results, treatment types and outcomes of your treatment;
4. Sending specimens, such as blood samples or pap smears, for analysis;
5. Referral to a hospital for treatment and/or advice;
6. Advice on treatment options;
7. The management of our practice;
8. Quality assurance, practice licencing and accreditation for: NATA (National Association of Testing Authorities), RTU (Reproductive Technology Unit, WA Dept. of Health), LARU (Licencing and Regulatory Unit, WA Dept. of Health), RTAC (Reproductive Technology Accreditation Committee), ANZICA (Australia and New Zealand Infertility Counsellors Association) and NPESU (National Perinatal Statistics Unit);
9. Complaint handling;

10. To meet our obligations of notification to medical defence organisations, Services Australia, the Department of Health and Aged Care or insurers;
11. To prevent or lessen a serious threat to an individual's life, health or safety; and
12. Where legally required to do so, such as producing records to courts, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

3. ISSUING OF CYCLE BLOOD RESULTS

Fertility North nurses will contact you with your blood test results and instructions for your treatment cycle.

Expected or "Normal" in-cycle results will be released to you via the Patient Portal. However, any unexpected in-cycle results or pregnancy test results will be given in-person via a phone call. So that these results may be given we request that you provide a mobile phone number with a personal voice mail facility NOT a voicemail to text system and be available to answer this phone or check your voicemail during the hours of: **12:00pm – 5.00pm Monday to Friday and 12:00pm – 4.00pm on Saturdays and public holidays.**

Fertility North nurses will try to contact you or your partner/next of kin three (3) times on the numbers you provide below. If they cannot reach you, it is your responsibility to contact Fertility North for your results and instructions. If the nurses still cannot reach you by phone, they will release your results via the Patient Portal.

Fertility North cannot be held liable for instances of incorrectly advised phone numbers, inaccessible voicemail message banks or the inability to contact you with your results after substantial effort has been made.

Please supply the best contact number for yourself and your partner or next of kin in the box below. We will contact you in the first instance however, if we cannot make contact with you, we will use the number of your partner or next of kin to provide your results.

Patient Name:		**Mobile Number:**	
Partner or Next of Kin Name:		**Mobile Number:**	

4. ACCESS

1. You are entitled to access your own health records at any time convenient to both yourself and the practice. Access can be denied where:
   i. There is a legal impediment to access;
   ii. The access would unreasonably impact on the privacy of another;
   iii. The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
   iv. In the interests of national security.
2. We ask that your request for access be in writing. We will impose a charge at standard rates for photocopying or for staff time and materials involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

5. USE OF A HEALTH CARE INTERPRETER

If a health care interpreter was used to assist in the completion of this consent form, please record the details below:

Interpreter Name:		**Date:**	
Job ID:	**Interpreter Registration ID:**		
FN Staff Member:			

6. CONSENT

I / WE

1. Give my consent for Fertility North to collect, use and disclose my personal information as outlined above.
2. Understand that access to my/our health records is an entitlement except where access would be denied as outlined above. ***ref Privacy Act 1988***
3. Acknowledge that limited identifying data on our ART cycle will be submitted to the NPESU as per Fertility North's accreditation requirements. ***ref RTAC***
4. Have been given time to consider the content of this document and I/we have been given the opportunity to make such further enquiries as I/we wish before signing. I/We also understand that we have the right to withdraw or vary consent (in writing) at any time.

SIGNATURES

Print Name: (Patient)		**Signature:**		**Date:**	
Print Name: (Patient's Partner)	N/A	**Signature:**		**Date:**	

FNC21 PATIENT RIGHTS AND RESPONSIBILITIES

References: Human Reproduction Technology Act (HRT Act) 1991, as amended by the Acts Amendment (Lesbian and Gay Law Reform) Act 2002 and the Human Reproduction Technology Amendment Act 2004, Current RTAC Code of Practice and Privacy Act 1988 (Cth)

I/We

Patient Details	Partner Details
Given Name: **Surname:** **Date of Birth:** **Street Address:** **Suburb & Postcode:** Patient Initial……	NA Partner Initial……

acknowledge that I/We have a special set of rights and responsibilities as a patient at Fertility North, and these are summarised below.

PATIENT RIGHTS

At the Clinic:

- You should be treated with respect, dignity and privacy.
- You should receive treatment and care in a clean and safe environment.
- You may be accompanied by a support person at most times, subject to health mandates, and be entitled to privacy and confidentiality for your personal and health information, except where the law permits this to be disclosed.
- You have a right to have access to treatment, including but not limited to, physical access to the facility.
- You have the right to complain either directly to Fertility North, using the email address: *admin@fertilitynorth.com.au* or you may report concerns to Australian Human Rights Commission and/or Health and Disability Services Complaints Office.

Medical Information:

- You are entitled to receive an explanation of the findings of investigation, the treatment proposed, alternative treatments, as well as the likely effects and outcomes.
- Costs for consults and procedures should be available to you to prevent unexpected expenses.

Treatment:

- During your treatment, certain tests and procedures may be carried out. It is in your own interest to discuss with your Clinician any treatment, examination, medication or procedure that you do not understand or do not desire.
- You have the right to access the results of any test or course of treatment carried out at Fertility North.
- You have a right to receive written information in plain English where appropriate to assist with treatment explanation.
- If you refuse treatment, or wish to discharge yourself, you may be asked to sign a form removing Fertility North from any liability caused by this refusal. However, you have the right to refuse any investigation or treatment you do not

want. If you chose to withdraw from treatment, you are still required to meet any outstanding financial obligations and/or incur a cancellation fee.

Consent:

- Certain treatments and procedures require your written consent. Before you sign the consent form, you must understand the nature of the treatment or procedure and what is involved.
- You have a right to receive useful and comprehensive information that is provided free from coercion and bias.
- You have a right to receive information that is provided at an appropriate level of understanding.
- You are entitled to refuse treatment if you wish, provided you advise relevant staff of your intentions to do so.

Interpreter Service:

- A confidential interpreter service is offered to patients who wish to speak or have information translated into their own language, subject to availability.
- Should you or a family member require the services of an interpreter, please advise the Nursing or Administration staff who will make the necessary arrangements.
- Sign interpreters for people with hearing disabilities can also be arranged.
- Please provide as much notice as possible to enable appropriate services to be arranged in a timely manner.

Medical Records:

- Records are kept of your investigations and treatment, which are confidential and secure. Access to your medical records is limited to health care professionals directly involved in your care. This record and any medical images taken remain the property of Fertility North.
- Fertility North acknowledges the use of an AI Medical Scribe tool during consultations with our Clinicians. The AI scribe securely listens in the background throughout the consultation, the treating Clinician then enables the generation of detailed clinical notes to be transferred into your medical record. The tool adheres to the Privacy Act 1988 and the Australian Privacy Principles (APP) to ensure your data is secure and protected. Your participation in the use of this tool is completely voluntary. Your consent to the use of the AI scribe will be requested prior to the start of your consultation.
- The contents of your medical record will be released only with your consent, or when required by law. You have a right to access your personal records under the *Freedom of Information Act (FOI) 1991.*
- An administration fee is charged for this application.

PATIENT RESPONSIBILITIES

Whilst you do have rights as a patient at Fertility North, you also have some responsibilities as summarised below. These responsibilities extend into your interactions with digital media.

General Behaviour:

Fertility North acknowledges that a treatment journey managing infertility can have its ups and downs which can be associated with extreme emotions which may influence behaviour. However, our staff members have the right to carry out their duties without fear of rudeness, disrespect, abuse, aggression or violence and all patients should be able to regard Fertility North as a safe and secure environment.

In light of this patients attending Fertility North should;

- Treat Fertility North staff and other patients with care, dignity and consideration at all times including during telephone conversations and in digital media posts.

- Respect the privacy of other Fertility North patients. The disclosure of any information relating to other patients of Fertility North including their presence at Fertility North is unacceptable.
- At all times, be respectful and considerate to Fertility North staff and other patients. This includes the avoidance of placing unrealistic demands on Fertility North staff as this undermines the clinic's ability to provide high quality care for other patients.

This kind of behaviour will not be tolerated and if necessary, Fertility North reserves the right to invoke several possible sanctions, including but not limited to;

- A verbal warning that your behaviour is breaching acceptable standards.
- The issue of a formal warning notice;
- You being asked to leave the clinic. If requested to leave, failure to comply may result in the Joondalup Health Campus Security Department being called;
- Suspension or termination of treatment;

Attendance at the Clinic:

- Please ensure that you have a current GP referral to your Clinician and provide a copy of this to the Administration staff. Failure to have a current referral will result in your being ineligible for a Medicare subsidy for the cost of your visit. It is not the responsibility of Fertility North to ensure your referral is up to date.
- You must attend your scheduled appointments or inform staff with at least 24 hours' notice (not including weekends) if you need to change an appointment. Failure to do so may incur a fee.
- Always provide staff with accurate information about your health and your current treatment and inform Fertility North staff if your condition or circumstances change.

Preparing for Treatment:

- Please inform the Doctor if you are receiving treatment from another health professional.
- Ensure that you understand what Private or Medicare Health Cover is available to you to avoid any unexpected costs.
- Ensure all outstanding accounts have been paid to prevent delays or cancellation of treatment.
- Always read the patient information materials provided to you by Fertility North so that you are well informed, understand your treatment and can ask questions if you are unsure.

Receiving Treatment:

- Whilst Fertility North Doctors will be happy to provide second opinions concerning management from patients currently having treatment from other Fertility providers, this must be done with full disclosure and not covertly. Fertility North Doctors will not co-manage patients with other practitioners unless they initiate the process themselves.
- Complete all relevant paperwork with accuracy and honesty to the best of your knowledge.
- Update and/or disclose to Fertility North any change in condition or circumstance that may impact on your clinical and/or financial and/or emotional state(s).
- Always follow your prescribed treatment, as well as any other instructions given. Fertility North cannot be responsible for disappointing outcomes if instructions are not adhered to.
- Do not discontinue treatment or prescribed medications without sound clinical advice.
- Please ask questions about anything you do not understand.

CONSENT

I / We

- Acknowledge the patient rights and responsibilities as outlined above.
- Have been given time to consider the content of this document and have been given the opportunity to make further enquiries as I/we wish before signing.
- Understand that we have the right to withdraw this consent (in writing) at any time, but that this may result in withdrawal of treatment by Fertility North.

SIGNATURES

Print Name: (Patient)		**Signature:**		**Date:**	
Print Name: (Patient Partner)	NA	**Signature:**		**Date:**	

USE OF A HEALTH CARE INTERPRETER

If a health care interpreter was used to assist in the completion of this consent form, please record the details below:

Interpreter Name:		**Date:**	
Job ID:	**Interpreter Registration ID:**		
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