Your First Appointment

Welcome to Fertility North

Fertility North is a boutique fertility clinic located in the City of Joondalup, Perth, Western Australia.

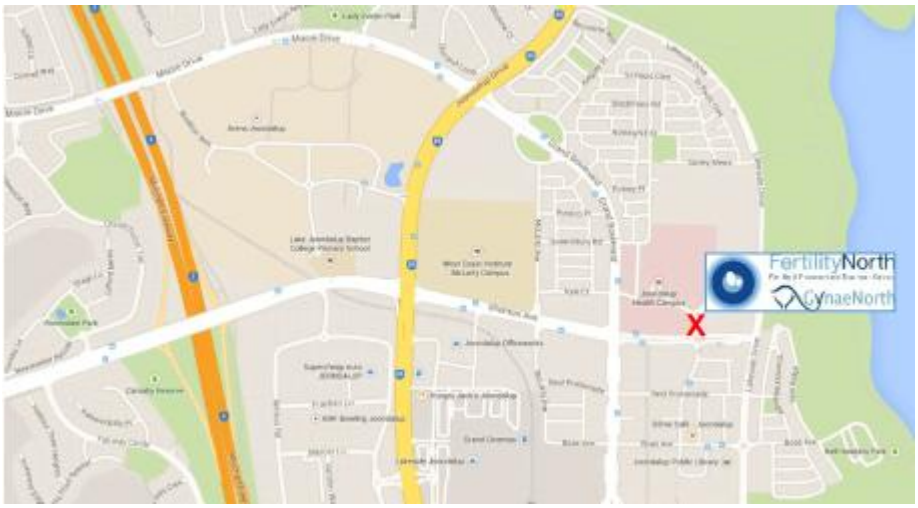
If you have any further questions, please do not hesitate to contact us by phone or email. We would love to hear from you.

Where is Fertility North Located?

Fertility North is conveniently located at Joondalup Private Hospital.

Suite 30, Level 2
Joondalup Private Hospital
60 Shenton Avenue
Joondalup WA 6027

Telephone: +61 (08) 9301 1075



Parking

The closest carparks within the Joondalup Health Campus premises are Carpark **P12B and P9** (see access on the map below).

Parking is charged at an hourly rate ($2/hr) from 8am 'til 6pm weekdays and 8am 'til 12pm on Saturday. Parking is free on Sunday and Public Holidays. These carparks are monitored and patrolled by the City of Joondalup.

Carpark **12A**, located in front of the Private Hospital entrance, allows a free 30 minute maximum parking (bays are limited).

Your First Appointment

How Much Time Should We Allow?

Every patient attending Fertility North is unique and as such, we strive to provide treatment that is personalised to your own needs. We would recommend that you allow at least one hour for this first appointment.

For patients attending from outside the metropolitan area, some of the additional tests may have been pre-arranged to coincide with your first appointment. In this case, you may need to allow more time and staff will advise you of this in advance.

What Should We Bring?

- ☐ Completed Medical Information Form
- ☐ Completed Clerical Information Sheet
- ☐ Completed Patient Rights & Responsibilities Form
- ☐ Consent Forms
- ☐ Photographic ID i.e. Passport / Driving Licence
- ☐ Medicare Card(s)
- ☐ Copy of any test results in the last year (including any Pap Smear / Cervical Screening)
- ☐ Your partner, if you have one.

What Can We Expect?

Your first appointment at Fertility North will be with one of our Fertility Specialists or our Fertility GP, who will consult with you for up to 60 minutes. During which time you will discuss the information you have provided in your history forms and a physical examination may also be performed.

You will be given or emailed a New Patient Information Pack, and our friendly nursing staff will call you 2 working days after your initial consult with your doctor. During this phone call you will be given an overview of how your investigations will proceed at Fertility North (and elsewhere), including what is required for each test and when they should be done.

These tests may include:

- *Initial screening test*: Including blood tests and urine samples for both partners. For your convenience, some of these tests may be done after your initial appointment.
- *Semen Analysis, Trial Preparation, Halosperm / DNA Fragmentation and/or Antisperm Antibodies (Male Patient)*
- *A Tracking Cycle (Female Patient)*
- *An Ultrasound (Female Patient and sometimes the Male Patient)*
- *A Hysterosalpingogram (HSG) (Female Patient);* and/or
- *A Laparoscopy (Female Patient)*

Your Specialist / Doctor will usually recommend a review appointment 6-8 weeks after your initial consultation with them. At this review appointment, the results of the investigations will be explained and you will discuss your best treatment options.

Additional Information

For further information or support on any of the above please do not hesitate to contact staff at Fertility North.

To find out more about who we are and what we do please feel free to explore our website:

http://www.fertilitynorth.com.au

or our Facebook page:

https://www.facebook.com/fertilitynorth

From all of us at Fertility North, we welcome you and look forward to supporting you on your journey.

FertilityNorth
Fertility & Endocrinology Treatment Centre
GynaeNorth

CLERICAL INFORMATION SHEET

DATE:

*Denotes mandatory field

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

	Patient 1 Information	Patient 2 Information ☐ N/A
File Number *(office use only)*		
Title *(Miss/Mr/Mrs/Ms/Mx/Dr)*		
***Surname**		
***Given Names(s)**		
Preferred Name *(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)*		
***Date of Birth**		
***Place of Birth** *(Country if outside Australia)*		
***Street Address**		
***Suburb/Post Code**		
***Mobile Telephone**		
***Email Address**		
***Occupation**		
Marital Status *Please tick applicable*	☐ Married ☐ De Facto ☐ Single	
***Are you or your partner FIFO / DIDO?**	☐ Yes ☐ No	☐ Yes ☐ No
***How did you hear about us?**	☐ GP ☐ Specialist ☐ Friend/Family	☐ Website ☐ Social Media ☐ Other

Medicare Number		
Medicare Reference #	**Expiry:**	**Expiry:**
Private Hospital Cover? *(Not ancillary or extras cover)* *Please tick applicable*	☐ Yes, I have Private Hospital Cover ☐ No, I do not have Private Hospital Cover	☐ Yes, I have Private Hospital Cover ☐ No, I do not have Private Hospital Cover
If yes, have you had this private hospital cover for more than 12 months? *Please tick applicable*	☐ Yes (Name of fund _____) ☐ No	☐ Yes (Name of fund _____) ☐ No
If yes, Private Health Fund Membership Number:		
When did you and your partner begin trying to conceive?	**Month:**	**Year:**
***Have you had IVF before?**	☐ Yes ☐ No	☐ Yes ☐ No
***If yes, please write the name of the clinic(s)**		

Have you been hospitalised outside Western Australia in the past 12 months? *(Please tick applicable)*	☐ Yes ☐ No	☐ Yes ☐ No
If yes, Nasal Swab?	☐ Negative ☐ Positive	☐ Negative ☐ Positive

Referring Doctor Name		**Date of Referral**	
Referring Doctor Address			

Patient Identification Sheet

Please click the boxes to upload photographs of the required cards

Treating Patient

ID	Medicare
Sample Signature	**Private Insurance (if applicable)**

Patient Partner

N/A ☐

ID	Medicare
Sample Signature	**Private Insurance (if applicable)**

MEDICAL INFORMATION

Please disregard MALE PARTNER section of this form if you are a single woman or a same sex couple

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

Height (cm)		Weight (kg)		BMI	
Ethnicity					
Occupation					

Height (cm)		Weight (kg)		BMI	
Ethnicity					
Occupation					

PART I - FEMALE PATIENT INFERTILITY HISTORY

When did you and your partner start trying to conceive?	Month: _____ / Year:_____
During that time have you lived apart or avoided pregnancy? (tick)	Yes ☐ (Duration:_____) / No ☐
Do you or your partner work FIFO?	Yes ☐ (Usual Roster:_____ on/_____off) / No ☐

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 been investigated or treated for Infertility before?	No ☐ *(move on to Part II)* Yes ☐ *(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 II – FEMALE PATIENT 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 days?					
Average number of days of bleeding?					
Flow (tick)	☐ Light ☐ Normal ☐ Heavy	Pain (tick)	☐ Mild-None ☐ Moderate ☐ Severe		
Do you have bleeding between periods? (tick)	☐ 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	
How often have you had intercourse in the last 6 months?	_____ times per Month ☐ Week ☐ (tick)		
Do you try to identify your most fertile time of the month? (tick)	☐ Yes ☐ No	Describe	

PREVIOUS GYNAECOLOGICAL SURGERY			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

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

PREGNANCIES				
Pregnancies	Month / Year	Outcome*	Duration (w)	Previous Partner (Y / N)
1st				
2nd				
3rd				
4th				
5th				

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

PART III – FEMALE PATIENT MEDICAL & FAMILY HISTORY

MEDICINES	
List Allergies to Medicines	List Prescribed Medications
1.	1.
2.	2.
3.	3.
4.	4.

Do you use complementary medicines? (tick)	☐ 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.			

PART IV - MALE PARTNER INFERTILITY HISTORY ☐ N/A

Have you had any pregnancies with previous partners?			
Have you had a history of infertility with a previous partner? (tick)	☐ Yes ☐ No	Describe	
Have you had any trauma to the genitals area? (tick)	☐ Yes ☐ No	Describe	

PREVIOUS UROLOGICAL / GROIN SURGERY (if applicable)			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

Have you been ever diagnosed with an STI? (tick)	☐ Yes ☐ No	Describe	
Have you ever had a semen analysis? (tick)	☐ Yes ☐ No	If yes, please bring a copy of the report to your consultation.	
Do you ever have any erectile or ejaculatory difficulties? (tick)	☐ Yes ☐ No	Describe	

PART V – MALE PARTNER MEDICAL & FAMILY HISTORY ☐ N/A

MEDICINES	
List Allergies to Medicines	List Prescribed Medications
1.	1.
2.	2.
3.	3.
4.	4.
Do you use complementary medicines? (tick) ☐ 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.			

PART VI – LIFESTYLE

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

Is there anything else not covered that you or your partner feels may be relevant?

FertilityNorth
Fertility & Endometriosis Treatment Centre
GynaeNorth

FNC20 CONSENT TO CONTACT PATIENT WITH RESULTS

References: Privacy Act 1988

I / We

	Patient Details	**Partner Details** (if applicable)
Full name		
Date of Birth *(DD-MM-YYYY)*		

consent to Fertility North contacting me with my daily blood results and instructions.

ACKNOWLEDGEMENTS

I acknowledge that:

1. I own and use a mobile phone with a personal voicemail facility (not a voicemail to text system) and will be available to answer this phone or check my voicemail during the hours of **12:00pm – 5pm Monday to Friday and 12:00pm – 3pm on Saturdays and public holidays.**
2. I am responsible for being available for the nurses to contact me on the above-mentioned mobile phone during the stated hours.
3. The information given on this form is correct and I am responsible for informing Fertility North of any changes to my current contact details.
4. Should I not be available to answer my above-mentioned mobile phone, I authorise Fertility North nurses to leave a detailed voicemail message with results related instructions.
5. I understand that the responsibility lies with me to ensure I am available to receive the above mentioned telephone calls, or have a functional voicemail facility attached to the above mentioned mobile phone.

Patient Mobile Number:	
Patient Email Address*:	
Voicemail: I confirm that I have a personal voicemail service (not a voicemail to text system) attached to my supplied mobile phone number (above), which states my name, where the nurse can leave a message, if appropriate. *If you do not have a voicemail facility, we will not be able to provide this service and you will be responsible for phoning the clinic on (08) 9301 1075 between 2:30pm and 3:30pm Monday to Friday and 2:00pm to 2:30pm on Saturdays and public holidays.*	☐ Yes Initial:_____
Preferred contact time: we understand that you may be not able to use your phone during your work hours. In that case, please state your preferred time to be contacted during the call-out time stated above. We will make all reasonable efforts to call during this time however, we CANNOT guarantee it.	

** Please ensure you are comfortable with information pertaining to your treatment cycle, results and other sensitive information being emailed to you on the nominated email address.*

In the event I cannot be contacted on my supplied details, I give consent for my partner (if applicable), named above, to be contacted on his/her given details.	☐ Yes ☐ No Initial:_____
Partner's Mobile Number	
Voicemail: I confirm that my partner has a voicemail service (not a voicemail to text system) attached to their supplied mobile phone number (above), which states their name, where the nurse can leave a message on, if appropriate	☐ Yes ☐ No
Preferred contact time: we understand that your partner may be not able to use their phone during your work hours. In that case, please state their preferred time to be contacted during the call-out time stated above. We will make all reasonable efforts to call during this time however, we CANNOT guarantee it.	

Please be aware that Fertility North nurses will make a substantial effort to contact you and/or your partner on every occasion, however in the event we cannot contact you, the responsibility will fall with yourself.

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. Fertility North considers a substantial effort as the nurse attempting to contact you three (3) times on your nominated number, including your partner's (if appropriate) and leaving a voicemail message.

If after substantial effort, the nurses are unable to contact you or your partner by telephone, Fertility North will email your results to you using the email address you have provided. Please be aware that some of your results may be sensitive in nature, therefore, if you would prefer that your results NOT be sent via email, please tick this box. ☐

SIGNATURE

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

****Fertility North will provide you with a copy of this consent to you for your records****

FertilityNorth
Fertility & Endometriosis Treatment Centre
GynaeNorth

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:	Given Name:
Surname:	Surname:
Date of Birth:	Date of Birth:
Street Address:	Street Address:
Suburb & Postcode:	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 MEDICAL 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 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 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 MEDICAL INFORMATION

By signing this document, you are giving consent for 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 and practice accreditation for NATA (National Association of Testing Authorities), RTC (Reproductive Technology Council), RTAC (Reproductive Technology Accreditation Council), and NPSU (National Perinatal Statistics Unit);
9. Complaint handling;

10. To meet our obligations of notification to medical defence organisations 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. 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.

4. 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***
3. Acknowledge that limited identifying data on our ART cycle will be submitted to the NPSU 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:**	
Witness Name:** (FN Staff member or Approved 3rd Party Witness)		**Signature:**		**Date:**	
Witness Occupation:			**Registration ID** (if applicable)		
Witness Address:					

Print Name: (Patient's Partner)		**Signature:**		**Date:**	
Witness Name:** (FN Staff member or Approved 3rd Party Witness)		**Signature:**		**Date:**	
Witness Occupation:			**Registration ID** (if applicable)		
Witness Address:					

** Please note: The consent will not be accepted without the patient's signature being witnessed either by a Fertility North staff member or by an approved 3rd party witness. For a list of approved 3rd party witnesses, please see page 3 of this document.

List of Witnesses Approved by Fertility North for Procedures Other than Discard*

Fertility North Staff Member
Academic (post-secondary institution)
Accountant
Architect
Australian Consular Officer
Australian Diplomatic Officer
Bailiff
Bank Manager
Chartered Secretary
Chemist
Chiropractor
Company Auditor or Liquidator
Court Officer (Magistrate, Registrar or Clerk)
Defence Force Officer
Dentist
Doctor
Electorate Officer (State – WA only)
Engineer
Industrial Organisation Secretary
Insurance Broker
Justice of the Peace (any State)
Lawyer
Local Government CEO or Deputy CEO
Local Government Councillor
Loss Adjuster
Marriage Celebrant
Member of Parliament
Minister of Religion
Nurse
Optometrist
Patent Attorney
Physiotherapist
Podiatrist
Police Officer
Post Officer Manager
Psychologist
Public Notary,
Public Servant (State or Commonwealth)
Real Estate Agent
Settlement Agent
Sheriff or Deputy Sheriff
Surveyor
Teacher
Tribunal Officer
Veterinary Surgeon

**List of witnesses approved by Fertility North for consent forms NOT relating to the discard of gametes or embryos has been based on those witnesses who are approved by the Department of the Attorney General, Government of Western Australia.*

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:	Given Name:
Surname:	Surname:
Date of Birth:	Date of Birth:
Street Address:	Street Address:
Suburb & Postcode:	Suburb & Postcode:
Patient Initial……..	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, 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.

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, drug 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 x-rays taken remain the property of Fertility North.
- 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.
- You have the right to complain/lodge grievances either directly to Fertility North, using the email address: *admin@fertilitynorth.com.au* or report concerns to Australian Human Rights Commission and/or Health and Disability Services Complaints Office.

PATIENT RESPONSIBILITIES

Whilst you do have rights as a patient at Fertility North, you also have some responsibilities as summarised below. These responsibilities extend in to 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 a number of 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 of treatment for 6 months;
- Termination of treatment.

Attendance at the Clinic:

- Please ensure that you have a current GP referral to your Fertility Specialist 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 relevant 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 clandestinely. 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)		**Signature:**		**Date:**	

Semen Analysis – Test Instructions

What is a Semen Analysis and Why do I Need One?

It is very important when assessing a couple's fertility that the Doctor evaluates both partners. This enables them to diagnose the factors that might be contributing to the delay in conception and determine the sort of treatment that offers the best chance of success.

In assessing your fertility, your Doctor will ask for your medical history. They may conduct a physical examination and send you for some blood tests, but the main form of investigation is in the Laboratory, by way of a semen analysis. This involves the assessment of a patient's ejaculated semen sample by specially trained staff to determine: Sperm Count - the number of sperm present in the sample; Motility - The percentage of the sperm in the sample that are swimming; Morphology -the shape of the sperm; as well as volume, pH and MAR - the presence of anti-sperm antibodies on the sperm. Further information on any additional tests requested is available from Clinic staff.

Booking an Appointment

Semen Analysis, Trial Preparation, Halosperm (DNA Fragmentation test), MAR testing (Anti-sperm Antibody test) and Sperm Cryopreservation are carried out in the specialised Laboratory at Fertility North on selected weekdays, **by appointment only**.

This allows the Laboratory to have a Scientist exclusively allocated to carry out the testing on your sample as soon as it has been delivered, therefore avoiding any inaccuracies that delays in analysis might cause.

We recommend booking your appointment **at least a week** before your follow up consult to allow all test results to be completed by the Laboratory.

To book, please call the Laboratory on (08) 93011075. Information on costs can be obtained from Fertility North Reception.

Abstinence

One of the greatest misconceptions in society is that the longer you "save up your sperm", the more sperm you have and the better they will be. Instead, what happens is an accumulation of dead and dying sperm, which in turn have a negative impact on the quality and integrity of the live sperm that remain.

Fertility North recommends maintaining an interval of no more than 2-5 days between ejaculations to optimise sperm quality. Prior to a sperm test there needs to be between 1-2 ejaculations, 2-5 days apart to optimise the sperm quality available for the test. Failure to adhere to these requirements may necessitate a repeat test.

How is the Sample Obtained?

Samples are to be **produced by masturbation only, unless otherwise arranged with laboratory staff**, as lubricants, saliva, coitus interruptus and normal condoms can kill sperm.

In some circumstances, sperm can be present in the urine. If your Doctor requests this kind of analysis, the Laboratory will provide you with instructions for the collection of a urine sample specifically for the assessment of sperm in the urine.

If you think you might have problems producing, please do not worry, just contact the Laboratory on (08) 9301 1075 to discuss alternatives.

Where Can I do the Sample?

So that we can ensure that samples reach the Laboratory in optimum condition, patients are asked to attend the

Fertility North
Suite 30, Level 2
Joondalup Private Hospital
60 Shenton Avenue
JOONDALUP WA 6027

Tel: 08 9301 1075
Fax: 08 9400 9962

www.fertilitynorth.com.au

Semen Analysis – Test Instructions

clinic and produce a sample for analysis in a private, designated room adjacent to the Laboratory.

We understand that this may not suit everyone, so by arrangement, you can produce your sample at home and bring it into the Clinic. Please note that your sample must be delivered to the Laboratory **within 45 minutes of production**.

Your partner can deliver the sample on your behalf. If this is the case, they will be required to sign a form and they must bring with them the **Semen Collection Details** form as well as the **Doctor's Request Form.**

What Else do I Need to Know?

Please DO NOT take your sample to any other pathology provider. They may not be able to complete all of the tests requested. Please deliver your sample to Fertility North in Suite 30, Level 2, Joondalup Private Hospital, 60 Shenton Avenue Joondalup WA 6027.

Minimum 24 hours' notice of cancellation is required. Failure to cancel or attend your appointment will incur a missed appointment fee of $55 which cannot be claimed from Medicare. Please note your appointment must be cancelled in person with Laboratory staff only.

More information can be found at: http://www.fertilitynorth.com.au/pages/semen.html or on our Improving Sperm Quality Patient Information sheet.

For further information or support on any of the above, please do not hesitate to contact staff at Fertility North.