RAINBOW FERTILITY
your dream, our passion

REGISTRATION FORM

Rainbow Fertility would like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your treatment needs.

Please note that this registration form refers to partner 1 and partner 2. Where we refer to partner 1 we are referring to the primary person receiving fertility treatment. If both partners are undergoing fertility treatment please identify the patient undergoing egg collection as partner 1 and the patient undergoing the transfer as partner 2.

While at Rainbow Fertility we recognise different sexes/genders, many health bodies and legal entities do not. Please understand that the legal name and sex listed on your Medicare card must be used on documents pertaining to your health records and billing. However, please let us know if your preferred name and pronouns are different from these.

PARTNER 1 DETAILS				PARTNER 2 DETAILS (if applicable)			
Surname				**Surname**			
First Name				**First Name**			
Preferred or Former Name (if applicable)				**Preferred or Former Name** (if applicable)			
Date of Birth				**Date of Birth**			
Gender At Birth	☐ Female	☐ Male	☐ X	**Gender**	☐ Female	☐ Male	☐ X
Gender Identify As	☐ Female	☐ Male		**Gender Identify As**	☐ Female	☐ Male	
CONTACT DETAILS Please ensure that you add your preferred contact details. We will never identify ourselves as calling from Rainbow Fertility to anyone other than you. Please indicate if you would prefer Partner 2 to be the main contact.							
Address		**State**	**Post Code**	**Address (or as 'Partner 1')**		**State**	**Post Code**
Postal Address				**Postal Address**			
Medicare Number				**Medicare Number**			
Expiry Date		**Reference number**		**Expiry Date**		**Reference number**	
Private Health Fund Name and Number				**Private Health Fund Name and Number**			
Home Phone				**Home Phone**			
Mobile				**Mobile**			
Email Address				**Email Address**			
Occupation				**Occupation**			
Country of Birth				**Country of Birth**			
Height		**Weight**		**Height**		**Weight**	
Emergency Contact Name and Number				**Emergency Contact Name and Number**			
Known Allergies				**Known Allergies**			
Referring Family Doctor (GP)	**Name** **Address**						MANDATORY
Rainbow Fertility Specialist							MANDATORY

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ADDITIONAL REQUIREMENTS				
Do you or your partner require an interpreter?	☐ Yes		☐ No	
If yes, for which language?				
Do either of you have a physical disability?	☐ Yes		☐ No	
If yes, do you require Wheelchair Access?	☐ Yes		☐ No	
Are you or your partner visually or hearing impaired?	☐ Yes		☐ No	
If yes, do you require assistance for	☐ Hearing		☐ Seeing	
How did you hear about Rainbow Fertility?	☐ Radio	☐ Yellow Pages	☐ Social Media (Facebook/twitter)	☐ Friend or Relative
	☐ Magazine	☐ Newspaper	☐ White Pages	☐ Referring GP
	☐ Internet Search Engine		☐ Other	
Have you attended a Rainbow Fertility Information Evening?	☐ Yes		☐ No	

SEXUAL ORIENTATION

You will notice that we ask questions about gender and sexual orientation. We do this so that we can review the treatment that all patients receive and ensure that everyone gets the highest quality of care. Please note that completing this section is **optional.**

	PARTNER 1 DETAILS			PARTNER 2 DETAILS (if applicable)			
Sexual Orientation (optional)	☐ Lesbian	☐ Gay	☐ Bisexual	**Sexual Orientation (optional)**	☐ Lesbian	☐ Gay	☐ Bisexual
	☐ Heterosexual/ Straight	☐ Transgender	☐ Other		☐ Heterosexual/ Straight	☐ Transgender	☐ Other
Are you intersex?	☐ Yes	☐ No		**Are you intersex**	☐ Yes	☐ No	
Are you Transgender?	☐ Yes ☐ M2F ☐ F2M	☐ No		**Are you transgender?**	☐ Yes ☐ M2F ☐ F2M	☐ No	
Please complete the section below if you are Transgender							
Have you started taking hormones?	☐ Yes	☐ No		**Have you started taking hormones?**	☐ Yes	☐ No	
Have you undergone sexual realignment surgery?	☐ Yes	☐ No		**Have you undergone sexual realignment surgery?**	☐ Yes	☐ No	
Are you planning on undergoing realignment surgery in the near future?	☐ Yes	☐ No		**Are you planning on undergoing realignment surgery in the near future?**	☐ Yes	☐ No	

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REGISTRATION FORM

PARTNER 1

MEDICAL HISTORY

The confidentiality of your health information is protected in accordance with the Privacy Act 1988. Rainbow Fertility Confidentiality Policy is available on request

Have you ever smoked?	☐ Currently	☐ Previously Year Ceased:	☐ No
If yes, how many a day?			
Do you consume alcohol?	☐ Yes	☐ No	
If yes, how many glasses per week?			
Are you taking any regular medication/herbal remedies?	☐ Yes	☐ No	
If yes, what are they?			
Have you previously had surgery?	☐ Yes	☐ No	
If yes, please specify			
Have you had a general anesthetic before?	☐ Yes	☐ No	
Any problems with general anesthetics in the past?			
Significant medical history?	☐ Asthma	☐ Diabetes	☐ Epilepsy ☐ High Blood Pressure
Other?			

FEMALE FERTILITY HISTORY

If not applicable due to sex and/or gender please check here ☐ and skip to Male Fertility Section

Are your periods regular?	☐ Regular (beginning every 21-38 days)	☐ Irregular	☐ Absent	
What is the average duration of your cycle?	Days			
Has an explanation for your infertility been identified?	☐ Yes If yes, please record below	☐ No	☐ Not Applicable	
Tubal	☐ Pelvic Inflammatory Disease	☐ Previous Ectopic Pregnancy		
	☐ Sterilisation	☐ Multiple Tubal Causes		
	☐ Removal of Tube or Tubes	☐ Congenital Tubal Defect		
Endometriosis	☐ Mild	☐ Moderate	☐ Severe	☐ Not known
Polycystic Ovaries (PCO)	☐ Yes ☐ No	☐ Not known	**Ovulation Disorder**	☐ Yes ☐ No
Other				
Total Number of Pregnancies				
Number of Children in Current relationship		**Number of Children in Previous relationships**		
Number of Miscarriages & Weeks Gestation		**Number of Terminations**		
Number of Ectopic Pregnancies		**Number of Still Births & Weeks Gestation**		

Have you Previously Undergone Intrauterine Insemination Cycles	☐ Yes	Number of Cycles		WHEN		☐ No
Have you Previously Undergone IVF Cycles	☐ Yes	Number of Cycles		WHEN		☐ No
Have you previously frozen Embryos	☐ Yes	Number of Cycles		WHEN		☐ No

REGISTRATION FORM

PARTNER 1 continued

MALE FERTILITY HISTORY *If not applicable due to sex and/or gender please check here* ☐		
Azoospermia (no sperm)	☐ Yes	☐ No
Oligospermia (low sperm count)	☐ Yes	☐ No
Decreased Motility	☐ Yes	☐ No
Abnormal Sperm Morphology	☐ Yes	☐ No
Endocrine Disorders	☐ Yes	☐ No
Sterilisation (Vasectomy)	☐ Yes	☐ No
Unsuccessful Vasectomy Reversal	☐ Yes	☐ No
Other	☐ Yes	☐ No

Number of Children in Current relationship		**Number of Children in Previous relationship**				
Have you Previously Undergone Surrogacy	☐ Yes	Number		WHEN		☐ No
Have you previously frozen Embryos/Gametes	☐ Yes	Number		WHEN		☐ No

CONSENT PARTNER 1			
I,		**DOB:**	____/_____/_____
Give permission for the following person/s to accept my blood test results on my behalf:			
1. Name:		**Relationship to Partner 1**	
2. Name:		**Relationship to Partner 1**	
I declare that the above information is correct.			
PARTNER 1 SIGNATURE		**DATE**	

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REGISTRATION FORM

PARTNER 2

If not applicable please check here ☐

MEDICAL HISTORY

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Have you ever smoked?	☐ Currently	☐ Previously Year Ceased:	☐ No
If yes, how many a day?			
Do you consume alcohol?	☐ Yes	☐ No	
If yes, how many glasses per week?			
Are you taking any regular medication/herbal remedies?	☐ Yes	☐ No	
If yes, what are they?			
Have you previously had surgery?	☐ Yes	☐ No	
If yes, please specify			
Have you had a general anesthetic?	☐ Yes	☐ No	
Any problems with this?			
Significant medical history?	☐ Asthma	☐ Diabetes	☐ Epilepsy ☐ High Blood Pressure
Other?			

FEMALE FERTILITY HISTORY

If not applicable due to sex and/or gender please check here ☐ and skip to Male Fertility Section

Are your periods regular?	☐ Regular (beginning every 21-38 days)	☐ Irregular	☐ Absent	
What is the average duration of your cycle?	Days			
Has an explanation for your infertility been identified?	☐ Yes If yes, please record below	☐ No	☐ Not Applicable	
Tubal	☐ Pelvic Inflammatory Disease	☐ Previous Ectopic Pregnancy		
	☐ Sterilisation	☐ Multiple Tubal Causes		
	☐ Removal of Tube or Tubes	☐ Congenital Tubal Defect		
Endometriosis	☐ Mild	☐ Moderate	☐ Severe	☐ Not known
Polycystic Ovaries (PCO)	☐ Yes ☐ No	☐ Not known	**Ovulation Disorder**	☐ Yes ☐ No
Other				
Total Number of Pregnancies				
Number of Children in Current relationship		**Number of Children in Previous relationships**		
Number of Miscarriages & Weeks Gestation		**Number of Terminations**		
Number of Ectopic Pregnancies		**Number of Still Births & Weeks Gestation**		

Have you Previously Undergone Intrauterine Insemination Cycles	☐ Yes	Number of Cycles		WHEN		☐ No
Have you Previously Undergone IVF Cycles	☐ Yes	Number of Cycles		WHEN		☐ No
Have you previously frozen Embryos	☐ Yes	Number of Cycles		WHEN		☐ No

REGISTRATION FORM

PARTNER 2 continued

MALE FERTILITY HISTORY If not applicable due to sex and/or gender please check here ☐						
Azoospermia (no sperm)	☐ Yes		☐ No			
Oligospermia (low sperm count)	☐ Yes		☐ No			
Decreased Motility	☐ Yes		☐ No			
Abnormal Sperm Morphology	☐ Yes		☐ No			
Endocrine Disorders	☐ Yes		☐ No			
Sterilisation (Vasectomy)	☐ Yes		☐ No			
Unsuccessful Vasectomy Reversal	☐ Yes		☐ No			
Other	☐ Yes		☐ No			
Number of Children in Current relationship		**Number of Children in Previous relationship**				
Have you Previously Undergone Surrogacy	☐ Yes	Number		WHEN		☐ No
Have you previously frozen Embryos/Gametes	☐ Yes	Number		WHEN		☐ No

CONSENT PARTNER 2			
I,		**DOB:**	___/___/_____
Give permission for the following person/s to accept my blood test results on my behalf:			
1. Name:		**Relationship to Partner 2**	
2. Name:		**Relationship to Partner 2**	
I declare that the above information is correct.			
PARTNER 2 SIGNATURE		**DATE**	

RAINBOW FERTILITY CENTRE - PRIVACY COLLECTION STATEMENT

Rainbow Fertility is the party collecting the information in this form. You can contact us at info@rainbowfertility.com.au or write to us at PO Box 3298 Newmarket 4051.

Rainbow Fertility uses the information you provide us in order to provide you with our services. Such information may include sensitive personal information relating to your health. Rainbow Fertility may also use the details we collect from you, including any email address you give to us, to send you information and direct marketing communications about our products, services, or any other activities which we consider may be of interest to you.

Some of the information we ask you to provide may be identified as mandatory or voluntary. If you do not provide the mandatory information, we may be unable to provide our services to you.

We may disclose the information provided under this form to various health and reproductive related organisations, including but not limited to the types of persons or organisations set out in sections 3 and 6 of Rainbow Fertility's Privacy Policy (which is accessible via the hyperlink below or can be provided to you upon request). Rainbow Fertility's Privacy Policy also sets out the process as to how you can access and correct any of your personal information collected under this form including how you can make a complaint.

It is possible that some of the information collected via this form may be disclosed to our IT service providers for the purpose of data hosting.

You may unsubscribe from receiving any further communication from us at any time. If you do not wish to receive direct marketing communications from Rainbow Fertility, please contact us via the details provided above.

Your personal information will be handled by Rainbow Fertility in accordance with the *Privacy Act 1988* (Cth) and our Privacy Policy (which is available at www.rainbowfertility.com.au)

http://rainbow.dev.icreatesolutions.com.au/wp-content/uploads/2015/12/Rainbow-Fertility-Privacy-Policy.pdf or can be provided to you on request by Rainbow Fertility.

Current as at 8th March 2016