Annamnese beide englisch- Auszug

Kinderwunschzentrum Dresden
Prager Str. 8a
01069 Dresden
Telefon: +49 (0) 351 5014000
Telefax: +49 (0) 351 50140028
www.ivf-dresden.de

Registration for woman

Name, first name:		**Profession:**	
Date and place of birth:		**Mobile phone number:**	
Country, zip code, city		**Street, house number:**	
E-mail address:			
Treating gynaecologist: name and address			
Report to your treating gynaecologist?	☐ Yes ☐ No		
Marital status	☐ married to treatment partner ☐ single ☐ divorced ☐ married otherwise		
Health insurance:	☐ statutory health insurance (German GKV) ☐ private health insurance		

Declaration (in case of private health insurance or foreign health insurance):

The claim for reimbursement is directed directly against the treated person and is independent of a possible reimbursement. I am aware that, as a private patient, I am fully liable for payment myself. I undertake to pay the invoice upon receipt without deduction. The billing will be done according to the valid rates according to the current version of the GOÄ of 09.02.1996 and will be invoiced at 2.3 times the fee rate. In addition, individual services can generally be charged at 3.5 times the fee rate. If both partners participate in a consultation for infertility treatment, each partner will be billed separately. Certain external services (like laboratory examinations, tissue samples or radiological examinations) may be necessary for the treatment that are not provided by the "Kinderwunschzentrum Dresden".

Consent to unencrypted e-mail communication

I hereby give my consent to unencrypted e-mail communication with the "Kinderwunschzentrum Dresden" to send me reports and medical letters, in this respect I release the staff at the "Kinderwunschzentrum Dresden" from confidentiality. I assure that I either have sole access to the above-mentioned e-mail box or that I consent to other persons that have access, to view my communication with the "Kinderwunschzentrum Dresden".

I agree: ☐ **I do not agree:** ☐

Obligation of confidentiality and data protection (DSGVO/ GDPR)

To treat you and your partner at the "Kinderwunschzentrum Dresden", it is necessary that we discuss the findings with you and your partner and to inform you about treatments and the resulting consequences, appointments and other information. For this purpose, it is absolutely necessary that you release each other (you and your partner) from the obligation of confidentiality. Also, we recommend to release your external physicians from the obligation of confidentiality towards us, so that we can exchange necessary information and treatment data with our colleagues. I hereby release the physicians and medical assistants of the "Kinderwunschzentrum Dresden" from the medical confidentiality towards my partner as well as my external physicians. Furthermore, I confirm that the patient information on data protection (privacy notice) is available for inspection in the practice and that I have been able to ask questions about it in the practice.

I declare my consent that my patient data will be collected and processed at the "Kinderwunschzentrum Dresden". I declare my consent that the "Kinderwunschzentrum Dresden" may request treatment data and findings concerning me from other physicians and service providers for the purpose of documentation and further treatment.

I declare my consent that treatment data and findings concerning me may be transmitted to other doctors and service providers treating me. This also includes, for example, external laboratories that are providing special analyses (such as blood values) that are necessary for my treatment.

I am aware that I can revoke this declaration in whole or in part at any time in the future.

_____ _____

Place, date Patient’s signutaure

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Registration for man

Name, first name:	**Profession:**
Date and place of birth:	**Mobile phone number:**
Country, zip code, city:	**Street, house number:**
E-mail address:	
Treating urologist: name and address	
Marital status:	☐ married to treatment partner ☐ single ☐ divorced ☐ married otherwise
Health insurance:	☐ statutory health insurance (German GKV) ☐ private health insurance

Declaration (in case of private health insurance or foreign health insurance):
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I agree: ☐ **I do not agree:** ☐

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I declare my consent that my patient data will be collected and processed at the "Kinderwunschzentrum Dresden". I declare my consent that the "Kinderwunschzentrum Dresden" may request treatment data and findings concerning me from other physicians and service providers for the purpose of documentation and further treatment.

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I am aware that I can revoke this declaration in whole or in part at any time in the future.

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Place, date Patient's signature

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Datenschutzrechtliche Einwilligungserklärungen QS-ReproMed und D·I·R®

Die Patienteninformation zum Datenschutz bei der Weitergabe und Speicherung von Daten (Art. 13 und 14 DSGVO) zur Qualitätssicherung und wissenschaftlichen Auswertung einschließlich der Information über unsere Rechte konnten wir Einsehen und zur Kenntnis nehmen. Wir haben die Patienteninformation verstanden. Es ist uns bekannt, dass ich/wir diese Einwilligung jederzeit und ohne Angabe von Gründen mit Wirkung für die Zukunft gegenüber dem Kinderwunschzentrum Dresden widerrufen kann/können und mir/uns aus einer Verweigerung der Einwilligung keine Nachteile im Rahmen der ärztlichen Behandlung entstehen.

Einwilligung Datenweitergabe und Speicherung an AG QS ReproMed zur Qualitätssicherung Hiermit willige ich ein, dass das Kinderwunschzentrum Dresden pseudonymisierte Daten zum Zweck der Qualitätssicherung an die Datenannahmestelle der AG QS ReproMed bei der Ärztekammer Schleswig-Holstein übermittelt und dass diese Daten dort verarbeitet werden. Als personensorge-berechtigte/r Stellvertreter/in unseres Kindes willige ich zudem in die Übermittlung personenbezogener Daten unseres Kindes (z. B. des Geburtsmonats) ein.

	Name in Druckbuchstaben Frau	Name in Druckbuchstaben Mann
Datum	Unterschrift Patientin	Unterschrift Partner / Patient

Einwilligung Datenweitergabe und Speicherung an das Deutsche IVF-Register e. V. (D·I·R)® zur wissenschaftlichen Auswertung
Hiermit willige ich ein, dass das Kinderwunschzentrum Dresden pseudonymisierte Daten zum Zweck der wissenschaftlichen Auswertung an das Deutsche IVF-Register e. V. (D.I.R. e. V.) übermittelt und dass diese Daten dort verarbeitet werden. Als personensorgeberechtigte/r Stellvertreter/in unseres Kindes willige ich zudem in die Übermittlung personenbezogener Daten unseres Kindes (z. B. des Geburtsmonats) ein.

Datum	Unterschrift Patientin	Unterschrift Partner / Patient

<u>Vom behandelnden Arzt auszufüllen</u>, wenn (ggf. auch von nur einer/m Beteiligten) keine Einwilligung erteilt wird:

☐ Der Patient bzw. die Patientin willigt nicht in die Übermittlung und Verarbeitung der oben genannten Daten an die **AG QS ReproMed** ein.

☐ Der Patient bzw. die Patientin willigt nicht in die Übermittlung und Verarbeitung der oben genannten Daten an das **(D·I·R)®** ein.