

Section A (patient or guardian / carer to complete)
☐ Updating existing patient details

Title	Given name(s)	Family name
<input style="width:90%;" type="text"/>	<input style="width:90%;" type="text"/>	<input style="width:90%;" type="text"/>

Preferred name	Date of birth (DD/MM/YY)
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Residential address	Suburb / Town	Postcode
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Postal address (if different from residential address)	Suburb / Town	Postcode
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Mobile number (or landline, if mobile not available)	Email address
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Are you of Aboriginal and / or Torres Strait Islander origin?

☐ No
 ☐ Yes, Aboriginal
 ☐ Yes, Torres Strait Islander
 ☐ Yes, both Aboriginal and Torres Strait Islander

Preferred contact person (if different from patient)	Relationship
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Mobile number (or landline, if mobile not available)	Email address
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

How would you like us to contact you? (You may select more than one option)

☐ Text message
 ☐ Email
 ☐ Phone
 ☐ Mail

Section B (patient or guardian / carer to complete)

• A Medicare card number is required to be eligible for PTSS.

Medicare card number	Expiry date (MM/YY)
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Please tick if any of the following apply to you:

	Card number	Expiry date (DD/MM/YY)	Card type (e.g. gold)
<input type="checkbox"/> Department of Veterans Affairs	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
<input type="checkbox"/> Healthcare card	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
<input type="checkbox"/> Pensioner concession card	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
<input type="checkbox"/> Commonwealth Seniors card	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Section C (patient or guardian / carer to complete)

The information provided is true and accurate at the time of application. I give my permission for Hospital and Health Service staff to obtain information about my / my child's / my ward's medical condition for the purpose of administering my application and providing relevant details to travel / accommodation providers as required. I understand that I must keep copies of receipts / invoices for accommodation and transport, and may be asked to provide these to Health and Hospital Service staff.

Patient (if 18 years or over) or Guardian / Carer (if under 18 years) signature	Date (DD/MM/YY)
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Guardian / Carer name (if applicable)	Contact number
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>

Hospital and Health Service use only

Identification number		
<input style="width:95%;" type="text"/>		
Proof of residency sighted / provided (e.g. QLD licence, electricity / gas bill, other acceptable documents)?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Concession card(s) sighted / provided?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sighted by: Staff name	Signature	Date (DD/MM/YY)
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>