Patient Travel Subsidy Scheme (PTSS)

**Travel referral** (Form B)

**Section A - Patient details (patient or referring clinician to complete)**

Has the patient's details changed? Yes No

Title Given name(s) Family name Date of birth (DD / MM / YY)

Medicare card number

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Expiry date (MM / YY)

/

Contact number

**Section B - Referral details (referring clinican to complete with details of treating specialist)**

Treating specialist name Speciality

 Travel referral is valid for 12 months (subject to review at any time).

Treatment facility name

Treatment facility address Suburb / Town Postcode Medical condition (include reason for referral)

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Is this the patient’s closest specialist? Yes No If *no*, provide reason

Interstate

Private patient

Clinical trial

Patient has lodged / intends to lodge a third party or Workers Compensation Claim regarding this treatment

**Appointment is for:**

Consultation

Treatment / Procedure

Review

Diagnostic

No

Yes

**If available, has telehealth been considered for this appointment?**

**Section C - Reason for travel (referring clinician to complete)**

**Appointment type:** Admission -

New Review

Outpatient -

New Review

# This condition may require ongoing travel for appointments? Yes No

**Appointment / Admission:** Date (DD / MM / YY) Time (HH : MM)

# Clinically recommended mode of travel:

Bus

Rail

Private motor vehicle Air

Weight of patient (kgs) - *for charter flights only*

Ferry Charter

**Clinical reason for selected mode of travel** (based on patient’s circumstances):

Patient has wheel chair

Patient has oxygen cylinder

Patient has a disability

English is not the patient's first language

# Further details on travel requirements:

**Section D - Accommodation (referring clinician to complete)**

Is the patient applying for a subsidy for accommodation\*?

Yes, private accommodation Yes, commercial accommodation Both No

Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.)

*\*As per the eligibility criteria. Approved by Hospital and Health Service.*

**Section E - Patient escort details (referring clinician to complete)**

Is the patient applying for a Patient Escort\*? Yes No

# Patient escort details:

Title Full name Date of birth (DD / MM / YY) Contact number Clinical reason

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Does the patient escort require accommodation?

Yes, same as patient Yes, different to patient No

*\*As per the eligibility criteria. Approved by Hospital and Health Service.*

**Section F - Declaration**

# Referring clinician (or clinicians nominated representative) declaration:

*I certify that the information provided on this form is correct. I have advised the patient or guardian / carer that Hospital and Health Service staff may contact the referring facility and travel / accommodation providers regarding this referral.* Referring clinician / nominated representative name

**Hospital and Health Service use only - Approval**

Identification number

**Subsidy approved for travel to: Mode of travel approved: Patient escort approved:**

**Accommodation approved:**

Place of referral

Private motor vehicle

Other

Air Bus

Train

Ferry

Other

Yes

Yes

No

No

Private accommodation Number of nights approved: Patient Patient escort

Commercial accommodation Number of nights approved:

Patient

Other

Patient escort

HHS to book

Transport

Accommodation

**Has it been determined if a telehealth alternative exists for this patient?**

If *no*, provide reason

Yes

No

Application not approved - provide reason

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|  | | *(Clinician stamp)* |
| Contact number Facility name  Signature Date (DD / MM / YY) | |
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| **Hospital and Health Service approval:**  Approver name | Signature | Date (DD / MM / YY) |
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| Approver name | Signature | Date (DD / MM / YY) |
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| Special consideration - provide reason |  |  |
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