Patient Travel Subsidy Scheme (PTSS)

**Patient registration** (Form A)

Updating existing patient details

**Section A (patient or guardian / carer to complete)**

# Title Given name(s) Family name

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Preferred name Date of birth (DD / MM / YY)

Residential address Suburb / Town Postcode Postal address (if different from residential address) Suburb / Town Postcode Mobile number (or landline, if mobile not available) Email address

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# 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

Mobile number (or landline, if mobile not available) Email address

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

# Text messsage Email Phone Mail

**Section B (patient or guardian / carer to complete)**

Medicare card number

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

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Please tick if any of the

Expiry date (MM / YY)

# /

following apply to you: Card number Expiry date (DD / MM / YY) Card type (e.g. gold)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Department of Veterans Affairs |  |  |  |  | / |  |  | / |  |  |
| Healthcare card |  |  |  |  | / |  |  | / |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Pensioner concession card |  |  |  |  | / |  |  | / |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Commonwealth Seniors card |  |  |  |  | / |  |  | / |  |  |

**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)

Guardian / Carer name (if applicable) Contact number

**Hospital and Health Service use only**

Identification number

Proof of residency sighted / provided (e.g. QLD licence, electricity / gas bill, other acceptable documents)? Concession card(s) sighted / provided?

Yes

Yes

No

No

**Sighted by:** Staff name Signature Date (DD / MM / YY)

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**Queensland Health**

PTSS Patient registration (Form A) v1.00 12/2018 Page 1 of 1