Queensland Government

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/YYYY):

Medicare number:	Expiry date (MM/YY):	Contact number:

Are you of Aboriginal and/or Torres Strait Islander origin?
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Section B – Referral details (referring clinician to complete with details of treating specialist)

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

Treating specialist name:	Specialty:

Treatment facility name:	

Treatment facility address:	Suburb / Town:	Postcode:

Medical condition (include reason for referral):	

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

Section C – Reason for travel (referring clinician to complete)

If available, has telehealth been considered for this appointment? ☐ Yes ☐ No

Appointment is for: ☐ Consultation ☐ Treatment / Procedure ☐ Review ☐ Diagnostic
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: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter	Weight of patient (kgs) - *for charter flights only:*

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:	Given name(s):	Family name:	Date of birth (DD/MM/YYYY):

Clinical reason:

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:		*(Clinician stamp)*
Contact number:	Facility name:	
Signature:	Date (DD/MM/YY):	

Hospital and Health Service use only – Approval

Identification number:

Subsidy approved for travel to: ☐ Place of referral ☐ Other: .....
Mode of travel approved: ☐ Private motor vehicle Air ☐ Bus ☐ Train ☐ Ferry ☐ Other
Patient escort approved: ☐ Yes ☐ No
Accommodation approved: ☐ Yes ☐ No
☐ Private accommodation Number of nights approved: Patient: ..... Patient escort: .....
☐ Commercial accommodation Number of nights approved: Patient: ..... Patient escort: .....
☐ HHS to book ☐ Transport ☐ Accommodation ☐ Other: .....

Has it been determined if a telehealth alternative exists for this patient? ☐ Yes ☐ No

If *no*, provide reason:

Hospital and Health Service approval

Approver name:	Signature:	Date (DD/MM/YY):
Approver name:	Signature:	Date (DD/MM/YY):

Special consideration - provide reason:

Application not approved - provide reason: