|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Travel Subsidy Scheme (PTSS)    Repatriation Request (Form E) | | | | | | | | | | | |
| **Section A – Patient details (patient representative, HHS or specialist to complete)** | | | | | | | | | | | |
| Title: | Given name(s): | | | | Family name: | | | | | | Date of birth (DD/MM/YYYY): |
| Date of death (DD/MM/YYYY): | | Place of death (Hospital / Facility name): | | | | | | | | | |
| Does the deceased identify as being of Aboriginal or Torres Strait Islander descent?:    No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, both Aboriginal and Torres Strait Islander | | | | | | | | | | | |
| **Patient escort details** | | | | | | | | | | | |
| Title: | Full name: | | | | | | | Date of birth (DD/MM/YYYY): | | | Contact number: |
| Notes: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Section B – Evidence** | | | | | | | | | | | |
| **Please attach evidence to facilitate transport** | | | | | | | | | | | |
| Life Extinct Form  Funeral Director invoice for transport  Other: | | | | | | | | | | | |
| Name of Funeral Director: | | | | | | | Contact details: | | | | |
|  | | | | | | | | | | | |
| **Section C – Return travel for Escort (if travel not booked, specialist or treating HHS to complete)** | | | | | | | | | | | |
| **Date ready to travel home** (DD/MM/YY): | | | | Morning  Afternoon | | | | | | | |
| **Recommended return mode of travel:**  Private motor vehicle  Air  Bus  Rail  Ferry | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Section D – Approving hospital details (Home HHS)** | | | | | | | | | | | |
| Hospital name: | | | | | | Contact person: | | | | Contact number: | |
| Transport authorised to: | | | | | | | | | | | |
| Transport details: | | | | | | | | | | | |
| Notes: | | | | | | | | | | | |
| **Section E – Escort declaration (Patient escort 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 the deceased patient for the purpose of administering my application. I understand that the family of the deceased patient is responsible for making the transport arrangements with the Funeral Director in consultation with Hospital and Health Service staff. I understand that repatriation is for transportation costs and excludes costs associated with the funeral service.* | | | | | | | | | | | |
| Escort signature: | | | | | | | Date (DD/MM/YY): | | | | |
|  | | | | | | | | | | | |
| **Hospital and Health Service use only**  *I, as the medical superintendent (or representative), authorise the above transport as required.* | | | | | | | | | | | |
| Approver name: | | | Approver signature: | | | | | | Date (DD/MM/YY): | | |
|  | | | | | | | | | | | |