Patient Travel Subsidy Scheme (PTSS)

**Appointment attendance** (Form C)

|  |
| --- |
| **Section A - Patient details (patient, HHS or specialist to complete)** |
| Title Given name(s) | Family name |  | Date of birth (DD / MM / YY) |
|  |  |  |  |  |
| Home hospital |  |  | Contact number |
|  |  |  |  |
| **Patient escort details:**Title Full name |  | Date of birth (DD / MM / YY) | Contact number |
|  |  |  |  |  |
| **Section B - Evidence (specialist to complete)** |  |
| **Part A: Please attach evidence of appointment attendance** |  |

Medicare receipt HICAPS receipt Discharge summary

|  |
| --- |
| **Part B: Please attach evidence of appointment attendance** |
|  | Date (DD / MM / YY) | Date (DD / MM / YY) |  | Date (DD / MM / YY) |
| **Appointment / Admission** |  |  | **Discharge** |  |

Complete details or provide stamp:

Specialist name

|  |  |
| --- | --- |
|  | *(Clinician stamp)* |
| Speciality Contact name (if not specialist)Treatment facility nameContact number Email |
|  |  |

*I certify that the patient received specialist medical treatment as stated above.*

Signature Date (DD / MM / YY)

Name (if not specialist) Position (if not specialist)

**Section C - Return travel (if travel not booked, specialist or treating HHS to complete)**

**Date ready to travel home** (DD / MM / YY) If not the same day as discharge, provide reason

|  |  |  |  |
| --- | --- | --- | --- |
| Morning Afternoon**Recommended return mode of transport:** Private motor vehicle If *air*, is a commercial flight medical clearance required? Yes | Air No | Bus Rail Ferry |  |
| **Section D - Ongoing treatments (specialist to complete)** |  |  |  |
| **Has the patient's treatment been completed?**If *no*, can future appointments be provided via Telehealth?Can ongoing treatment be provided at the patient's local hospital? | Yes YesYes | No NoNo |  |

**Details of next appointment** *(if further appointments are required - continue in section E, page 2)***:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date(approximate / TBA) | Appointment details(name / location) | Patient escort requested | Admission type | Appointment type | Speciality |
|  |  | Yes No | Inpatient Outpatient | Treatment ReviewConsultation |  |

**Clinically recommended mode of travel:** Private motor vehicle Air Bus Rail Ferry Clinical reason for selected mode of travel:

Clinical recommendation for escort:

Hospital and Health Service use only

Identification number

**Section E - Additional appointment details (clinician / clinician's nominated representative to complete)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Time (AM / PM) | type | required | required | Signature | Date |
| Admission | Admission type | Accommodation required | Patient escort required | Clinician declaration |
| Date | Time (AM / PM) | Signature | Date |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |
|  |  | Inpatient Outpatient | Yes No | Yes No |  |  |