

# Patient Travel Subsidy Scheme (PTSS)

## Travel application (Form B)

Use this step-by-step-guide to the **Travel application (Form B)** to apply for the Patient Travel Subsidy Scheme (PTSS). Parts of this form need to be completed by the clinician referring the patient. Information provided in this form will be used to determine the patient's eligibility for PTSS and the subsidy amount.

### Section A

To update personal details the Patient registration (Form A) must be filled out. Please provide the patient's personal details.

| Section A – Patient details                                                                                                                                                                                                                                       |                 |                                         |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------|-------------------------|
| Title:                                                                                                                                                                                                                                                            | Given name(s):  | Family name:                            |                         |
| Date of birth (DD/MM/YYYY):                                                                                                                                                                                                                                       | Contact number: | Medicare card number:<br>□□□□-□□□□□□-□□ | Expiry (MM/YY)<br>□□/□□ |
| Are you of Aboriginal and/or Torres Strait Islander origin?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, both Aboriginal and Torres Strait Islander |                 |                                         |                         |

### Section B

This section is to be completed by the clinician or nominated representative referring the patient.

The clinical reason for an escort must be completed.

| Section B – Patient escort details (referring clinician or nominated representative to complete)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Is the patient applying for an escort*? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |
| <b>Escort details:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                 |
| Title:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Given name(s):  |
| Family name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |
| Date of birth (DD/MM/YYYY):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Contact number: |
| <b>Clinical reason for escort:</b> An escort is medically required for the following reason/s:<br><input type="checkbox"/> Patient is a minor <input type="checkbox"/> Escort is the patient's legal guardian <input type="checkbox"/> Patient requires essential assistance<br><input type="checkbox"/> Patient requires lifesaving treatment <input type="checkbox"/> Escort provides active carer role <input type="checkbox"/> Language barriers<br><input type="checkbox"/> Patient has a physical or cognitive impairment <input type="checkbox"/> Cultural reasons which would inhibit attendance<br><input type="checkbox"/> Other (must provide clinical details): _____ |                 |
| Does the escort require accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 |

### Section C

This section should be completed by the clinician or nominated representative referring the patient.

The medical condition section should also include any special conditions which may impact or influence where the patient receives treatment.

| Section C – Treating specialist details (Where patient is being referred to)                       |                                                                          |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| • Travel application is valid for 12 months (subject to review at any time).                       |                                                                          |
| Treating specialist name:                                                                          | Specialty:                                                               |
| Treatment facility name:                                                                           | Clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Treatment facility suburb/town:                                                                    | Postcode:                                                                |
| <b>Medical condition and treatment required (include reason for referral):</b> _____               |                                                                          |
| Is this the patient's closest specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                          |
| If no, provide reason: _____                                                                       |                                                                          |

To register or update a patient's personal details please use the **Patient registration (Form A)**.

To confirm your attendance at an appointment please fill out the **Appointment attendance (Form C)**.



# Travel application (Form B)

## Section D

This section is to be completed by the clinician or nominated representative referring the patient. Providing more information will help a more informed decision to be made.

It is important to complete the clinical reason for selected mode of travel if the patient's travel is restricted such as mobility, disability, health condition, etc.

Further details on travel requirements can also be provided in this section, including accessibility requirements, restrictions to travel based on mode or distance, or if the patient requires assistance when travelling.

| Section D – Reason for travel (referring or nominated clinician to complete)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------|
| Appointment type: <input type="checkbox"/> Admission <input type="checkbox"/> Outpatient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |               |
| This condition may require ongoing travel for appointments <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |               |
| Appointment / Admission:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Date (DD/MM/YY): | Time (HH:MM): |
| Clinically recommended mode of travel:<br><input type="checkbox"/> Private motor vehicle <input type="checkbox"/> Air <input type="checkbox"/> Bus <input type="checkbox"/> Rail <input type="checkbox"/> Ferry <input type="checkbox"/> Charter <input type="checkbox"/> Shuttle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |               |
| <b>*Clinical reason for selected mode of travel (based on patient's circumstances).</b><br><b>Mode of travel defaults to the most economical mode if adequate information (e.g. clinical reason) is not provided:</b><br>Patient is not medically advised to travel via other travel modes due to:<br><input type="checkbox"/> Active clinical management <input type="checkbox"/> Pain management <input type="checkbox"/> Urgency <input type="checkbox"/> Restricted mobility<br><input type="checkbox"/> Life threatening condition <input type="checkbox"/> Musculoskeletal instability<br><input type="checkbox"/> Other (provide detailed clinical reason): _____<br>_____<br>Other reasons may include: Medical condition / patient's age / time of the appointment / length of travel time / to ensure patient's safety on arrival and access to accommodation (provide detailed clinical reason above).<br>_____<br><b>Further clinical details on travel requirements:</b> _____<br>_____<br><input type="checkbox"/> Patient has wheelchair <input type="checkbox"/> Patient has oxygen cylinder <input type="checkbox"/> Patient has a disability <input type="checkbox"/> English is not the patient's first language |                  |               |

## Section E

This section must be completed by the clinician or nominated representative referring the patient. It should include any further details to support the patient's need for accommodation, including any additional accommodation requirements.

| Section E – Accommodation (referring clinician or nominated representative to complete)                                             |
|-------------------------------------------------------------------------------------------------------------------------------------|
| Is the patient applying for a subsidy for accommodation*?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.):<br>_____ |

## Section F

Signature to certify information and acknowledgment of possible sharing of information. Clinician or nominated representative must sign this form as they are providing medical advice relating to the patient.

| Section F – Declaration                                                                                                                                                                                                                                                                                                                      |                  |                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------|
| <b>Referring clinician (or clinician's nominated representative) declaration:</b><br>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): |                   |

To register or update a patient's personal details please use the **Patient registration (Form A)**.

To confirm your attendance at an appointment please fill out the **Appointment attendance (Form C)**.



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### Section A

To update personal details the Patient registration (Form A) must be filled out. Please provide the patient's personal details.

| Section A – Patient details                                                                                                                                                                                                                                       |                 |                                         |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------|-------------------------|
| Title:                                                                                                                                                                                                                                                            | Given name(s):  | Family name:                            |                         |
| Date of birth (DD/MM/YYYY):                                                                                                                                                                                                                                       | Contact number: | Medicare card number:<br>□□□□-□□□□□□-□□ | Expiry (MM/YY)<br>□□/□□ |
| Are you of Aboriginal and/or Torres Strait Islander origin?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, both Aboriginal and Torres Strait Islander |                 |                                         |                         |

### Section B

This section is to be completed by the clinician or nominated representative referring the patient.

The clinical reason for an escort must be completed.

| Section B – Patient escort details (referring clinician or nominated representative to complete)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Is the patient applying for an escort*? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |
| Escort details:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |
| Title:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Given name(s):  |
| Family name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 |
| Date of birth (DD/MM/YYYY):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Contact number: |
| Clinical reason for escort: An escort is medically required for the following reason/s:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |
| <input type="checkbox"/> Patient is a minor <input type="checkbox"/> Escort is the patient's legal guardian <input type="checkbox"/> Patient requires essential assistance<br><input type="checkbox"/> Patient requires lifesaving treatment <input type="checkbox"/> Escort provides active carer role <input type="checkbox"/> Language barriers<br><input type="checkbox"/> Patient has a physical or cognitive impairment <input type="checkbox"/> Cultural reasons which would inhibit attendance<br><input type="checkbox"/> Other (must provide clinical details): _____ |                 |
| Does the escort require accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |

### Section C

This section should be completed by the clinician or nominated representative referring the patient.

The medical condition section should also include any special conditions which may impact or influence where the patient receives treatment.

| Section C – Treating specialist details (Where patient is being referred to)                       |                                                                          |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| • Travel application is valid for 12 months (subject to review at any time).                       |                                                                          |
| Treating specialist name:                                                                          | Specialty:                                                               |
| Treatment facility name:                                                                           | Clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Treatment facility suburb/town:                                                                    | Postcode:                                                                |
| Medical condition and treatment required (include reason for referral): _____                      |                                                                          |
| Is this the patient's closest specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                          |
| If no, provide reason: _____                                                                       |                                                                          |

To register or update a patient's personal details please use the **Patient registration (Form A)**.

To confirm your attendance at an appointment please fill out the **Appointment attendance (Form C)**.



# Travel application (Form B)

## Section D

This section is to be completed by the clinician or nominated representative referring the patient. Providing more information will help a more informed decision to be made.

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| Section D – Reason for travel (referring or nominated clinician to complete)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------|
| Appointment type: <input type="checkbox"/> Admission <input type="checkbox"/> Outpatient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |               |
| This condition may require ongoing travel for appointments <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |               |
| Appointment / Admission:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Date (DD/MM/YY): | Time (HH:MM): |
| Clinically recommended mode of travel:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |               |
| <input type="checkbox"/> Private motor vehicle <input type="checkbox"/> Air <input type="checkbox"/> Bus <input type="checkbox"/> Rail <input type="checkbox"/> Ferry <input type="checkbox"/> Charter <input type="checkbox"/> Shuttle                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |               |
| <b>*Clinical reason for selected mode of travel (based on patient's circumstances).</b><br><b>Mode of travel defaults to the most economical mode if adequate information (e.g. clinical reason) is not provided:</b><br>Patient is not medically advised to travel via other travel modes due to:<br><input type="checkbox"/> Active clinical management <input type="checkbox"/> Pain management <input type="checkbox"/> Urgency <input type="checkbox"/> Restricted mobility<br><input type="checkbox"/> Life threatening condition <input type="checkbox"/> Musculoskeletal instability<br><input type="checkbox"/> Other (provide detailed clinical reason): _____ |                  |               |
| <i>Other reasons may include: Medical condition / patient's age / time of the appointment / length of travel time / to ensure patient's safety on arrival and access to accommodation (provide detailed clinical reason above).</i>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |               |
| Further clinical details on travel requirements: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |               |
| <input type="checkbox"/> Patient has wheelchair <input type="checkbox"/> Patient has oxygen cylinder <input type="checkbox"/> Patient has a disability <input type="checkbox"/> English is not the patient's first language                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |               |

## Section E

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| Section E – Accommodation (referring clinician or nominated representative to complete)                                             |
|-------------------------------------------------------------------------------------------------------------------------------------|
| Is the patient applying for a subsidy for accommodation*?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.):<br>_____ |

## Section F

Signature to certify information and acknowledgment of possible sharing of information. Clinician or nominated representative must sign this form as they are providing medical advice relating to the patient.

| Section F – Declaration                                                                                                                                                                                                                                                                                                                             |                  |                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------|
| <b>Referring clinician (or clinician's nominated representative) declaration:</b><br><i>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.</i> |                  |                   |
| Referring clinician / nominated representative name:                                                                                                                                                                                                                                                                                                |                  | (Clinician stamp) |
| Contact number:                                                                                                                                                                                                                                                                                                                                     | Facility name:   |                   |
| Signature:                                                                                                                                                                                                                                                                                                                                          | Date (DD/MM/YY): |                   |

To register or update a patient's personal details please use the **Patient registration (Form A)**.

To confirm your attendance at an appointment please fill out the **Appointment attendance (Form C)**.

