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| Patient Travel Subsidy Scheme (PTSS)Patient registration (Form A) |
| **Section A (patient or guardian / carer to complete)** |
| [ ]  Updating existing patient details |
| Title: | Given name(s):      | Family name:      |
| Preferred name:      | Date of birth (DD/MM/YYYY):      |
| 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:      |
| 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 message [ ]  Email [ ]  Phone [ ]  Mail  |
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| **Section B (patient or guardian / carer to complete)** |
| * A Medicare card number is required to be eligible for PTSS.
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| Medicare number:      | Expiry date (MM/YY):      |
| **Please tick if any of the following apply to you:** |
| [ ]  Department of Veterans Affairs | Card number:       | Expiry date (DD/MM/YY):      | Card type (e.g. gold):      |
| [ ]  Healthcare card | Card number:      | Expiry date (DD/MM/YY):      |
| [ ]  Pensioner concession card | Card number:      | Expiry date (DD/MM/YY):      |
| [ ]  Commonwealth Seniors card | Card number:      | Expiry date (DD/MM/YY):      |
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| **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 to disclose relevant information, including a copy of this form, to approved travel / accommodation providers for the* *purpose of administration of the Patient Travel Subsidy Scheme (PTSS). I understand that I must keep copies of receipts /* *invoices for accommodation and transport, and may be asked to provide these to Hospital and Health Service staff.* |
| Patient (if 18 years or over) or Guardian / Carer (if under 18 years) signature: | Date (DD/MM/YYYY):      |
| Guardian / Carer name:      | Contact number:      |
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| **Hospital and Health Service use only** |
| Identification number:  |
| Proof of residency sighted / provided (e.g. QLD licence, electricity / gas bill, other acceptable documents)? [ ]  Yes [ ]  NoConcession card(s) sighted / provided? [ ]  Yes [ ]  No |
| **Sighted by** – staff name: | Signature: | Date (DD/MM/YYYY): |