|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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/YYYY): | | | |
| Home hospital: | | | | | | | | | | | | | | | | | | | | | | Contact number: | | | |
| **Patient escort details** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | Full name: | | | | | | | | | | | | | Date of birth (DD/MM/YYYY): | | | | | | | | 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** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Appointment / Admission** | | | | Date (DD/MM/YY): | | | | | | | | Date (DD/MM/YY): | | | | | | | | **Discharge** | | | Date (DD/MM/YY): | | |
| **Complete details or provide stamp** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialist name: | | | | | | | | | | | | | | | | | | *(Clinician stamp)* | | | | | | | |
| Specialty: | | | | | | | Contact name (if not specialist): | | | | | | | | | | |
| Treatment facility name: | | | | | | | | | | | | | | | | | |
| Contact 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): | | | | | | | | Morning  Afternoon | | | | | | | | | If not the same day as discharge, provide reason: | | | | | | | | |
| **Recommended return mode of travel:**  Private motor vehicle  Air  Bus  Rail  Ferry  If *air*, is a commercial flight medical clearance required?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section D – Ongoing treatments (referring clinician to complete)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the patient's treatment been completed?  Yes  No  If *no*, can future appointments be provided via Telehealth?  Yes  No  Can ongoing treatment be provided at the patient's local hospital?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | | | | | | Specialty |
|  | | |  | | | | | | | Yes  No | | | | | Inpatient  Outpatient | | | | Treatment  Review  Consultation | | | | | |  |
| **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 – Approval** | | | | | | | | | | | | | Identification number: | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section E – Additional appointment details (clinician / clinician's nominated representative to complete)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Admission | | | | | | Admission type | | | Accommodation required | | | | | | | Patient escort  requested | | | | | 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 | | | | |  | | |  | |
|  | |  | | | | Inpatient  Outpatient | | | Yes  No | | | | | | | Yes  No | | | | |  | | |  | |