|  |
| --- |
| 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 [ ]  FerryIf *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 [ ]  NoIf *no*, can future appointments be provided via Telehealth? [ ]  Yes [ ]  NoCan 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 escortrequested | Admission type | Appointment type | Specialty |
|       |       | [ ]  Yes[ ]  No | [ ]  Inpatient[ ]  Outpatient | [ ]  Treatment [ ]  Review[ ]  Consultation |       |
| **Clinically recommended mode of travel:** [ ]  Private motor vehicle [ ]  Air [ ]  Bus [ ]  Rail [ ]  FerryClinical 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 escortrequested | 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 |  |       |