Queensland Government

Patient Travel Subsidy Scheme (PTSS)

Travel application (Form B)

Privacy Statement:
Personal information collected by Queensland Health is handled in accordance with the Information Privacy Act 2009. Your personal information is being collected in order to assess whether you are eligible to receive a subsidy under the Patient Travel Subsidy Scheme. The personal information provided by you will be securely stored and made available to appropriately authorised officers of Queensland Health. Personal information recorded on this form will not be disclosed to other parties without your consent, unless the disclosure is authorised or required by or under law. For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please refer to our Privacy Policy. PTSS travel is assessed per the eligibility criteria (published in the PTSS guideline) and approved by individual Hospital and Health Services.

Section A – Patient details

Title:	Given name(s):	Family name:
Date of birth (DD/MM/YYYY):	Contact number:	Medicare card number: ☐☐☐☐-☐☐☐☐☐-☐☐ Expiry (MM/YY) ☐☐/☐☐

Are you of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Section B – Patient escort details (referring clinician or nominated representative to complete)

Is the patient applying for an escort*? ☐ Yes ☐ 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:

☐ Patient is a minor ☐ Escort is the patient's legal guardian ☐ Patient requires essential assistance
☐ Patient requires lifesaving treatment ☐ Escort provides active carer role ☐ Language barriers
☐ Patient has a physical or cognitive impairment ☐ Cultural reasons which would inhibit attendance
☐ Other (must provide clinical details): _____

Does the escort require accommodation? ☐ Yes ☐ No

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? ☐ Yes ☐ No
Treatment facility suburb/town:	Postcode:

Medical condition and treatment required (include reason for referral): _____

Is this the patient's closest specialist? ☐ Yes ☐ No

If *no*, provide reason: _____

Section D – Reason for travel (referring or nominated clinician to complete)

Appointment type: ☐ Admission ☐ Outpatient

This condition may require ongoing travel for appointments ☐ Yes ☐ No

Appointment / Admission:	Date (DD/MM/YY):	Time (HH:MM):

Clinically recommended mode of travel:

☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter ☐ Shuttle

***Clinical reason for selected mode of travel (based on patient's circumstances).**

Mode of travel defaults to the most economical mode if adequate information (e.g. clinical reason) is not provided:

Patient is not medically advised to travel via other travel modes due to:

☐ Active clinical management ☐ Pain management ☐ Urgency ☐ Restricted mobility

☐ Life threatening condition ☐ Musculoskeletal instability

☐ Other (provide detailed clinical reason): _____

_____

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).

Further clinical details on travel requirements: _____

_____

☐ Patient has wheelchair ☐ Patient has oxygen cylinder ☐ Patient has a disability ☐ English is not the patient's first language

Section E – Accommodation (referring clinician or nominated representative to complete)

Is the patient applying for a subsidy for accommodation*?

☐ Yes ☐ No

Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.):

_____

Section F – Declaration

Referring clinician (or clinician's nominated representative) declaration:

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):	

Hospital and Health Service use only – Approval

Identification number:

Subsidy approved for travel to: ☐ Place of referral ☐ Other:

Mode of travel approved: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter ☐ Shuttle

Patient escort approved: ☐ Yes ☐ No

Accommodation approved: ☐ Yes ☐ No

☐ Private accommodation Number of nights approved: Patient: _____ Patient escort: _____

☐ Commercial accommodation Number of nights approved: Patient: _____ Patient escort: _____

☐ HHS to book ☐ Transport ☐ Accommodation ☐ Other: _____

Has it been determined if a telehealth alternative exists for this patient? ☐ Yes ☐ No

If *no*, provide reason: _____

Hospital and Health Service approval

Approver name:	Signature:	Date (DD/MM/YY):
Approver name:	Signature:	Date (DD/MM/YY):

Special consideration - provide reason:

Application not approved - provide reason:

Date Form Received:	☐☐/☐☐/☐☐☐☐