User guide – **Travel referral (Form B)**

Use this step-by-step-guide to the Travel referral (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 their 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: ☐☐☐☐-☐☐☐☐☐-☐☐	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

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*? ☐ 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

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? ☐ 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: _____

*To register or update a patient's personal details please use the **Patient registration (Form A).***
*To confirm patient attendance at an appointment please fill out the **Appointment attendance (Form C).***

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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: ☐ 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

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*?

☐ Yes ☐ No

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

_____

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

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):	

*To register or update a patient's personal details please use the **Patient registration (Form A).***
*To confirm patient attendance at an appointment please fill out the **Appointment attendance (Form C).***

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