Queensland Government

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/YY)

Home hospital	Contact number

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	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

	Date (DD/MM/YY)	Date (DD/MM/YY)		Date (DD/MM/YY)
Appointment / Admission			**Discharge**	

Complete details or provide stamp:

Specialist name

Speciality

Contact name (if not specialist)

Treatment facility name

Contact number

Email

(Clinician stamp)

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 transport: ☐ Private motor vehicle ☐ Air ☐ Bus ☐ Rail ☐ Ferry

If *air*, is a commercial flight medical clearance required? ☐ Yes ☐ No

Section D - Ongoing treatments (specialist 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	Speciality
		☐ 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 Identification number

Section E - Additional appointment details (clinician / clinician's nominated representative to complete)

Date	Time (AM/PM)	type	required	required	Signature	Date
Admission		Admission type	Accommodation required	Patient escort required	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		