

User guide – Appointment attendance (Form C)

Use this step-by-step-guide to the Appointment attendance (Form C) to certify the patient attended their specialist appointment. This form also confirms how long the patient was medically required to be away from home.

Section A

- 1 Please provide the patient's personal details
To update personal details the **Patient registration (Form A)**, needs to be filled out.

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

- 2 Either part A or part B needs to be completed.
The patient can provide evidence for Part A and submit with this form.
or
The treating clinician needs to complete and sign part B.
- 3 Requires a signature from the specialist, representative or someone from the treating facility to certify the information provided in the form.

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

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)

(Clinician stamp)

To register or update a patient's personal details please use the **Patient registration (Form A)**.
To apply for PTSS please fill out the **Travel referral (Form B)**.

Section C

- 4 The date the patient is medically approved to travel home. Please provide reasons for the patient's requirement to travel after their discharge date (e.g. follow up appointments, admittance as an inpatient or not medically fit for travel).

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

- 5 To be completed by the treating clinician.
- 6 Please provide details of future appointments, if known. More space for future appointments is provided on the back of this form.

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
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Treatment <input type="checkbox"/> Review <input type="checkbox"/> Consultation	<input type="text"/>

Clinically recommended mode of travel: Private motor vehicle Air Bus Rail Ferry

Clinical reason for selected mode of travel:

Clinical recommendation for escort:

Section E

- 7 This section will notify the patient's home facility of future appointments and possible PTSS requirements. It is to be filled in and signed by the specialist or a representative.

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

Admission		Admission type	Accommodation required	Patient escort required	Clinician declaration	
Date	Time (AM/PM)				Signature	Date
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>