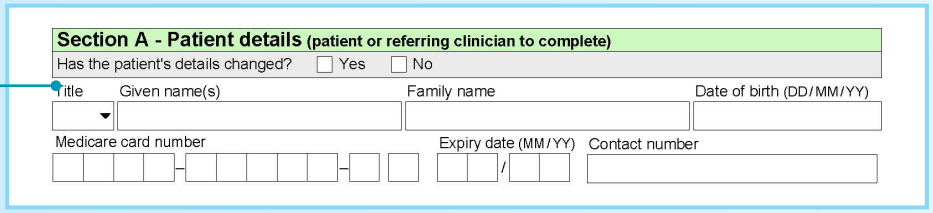
User guide – **Travel referral (Form B)**

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

1 To update personal details the **Patient registration (Form A)**, needs to be filled out.

Please provide the patient's personal details.



Section A - Patient details (patient or referring clinician to complete)

Has the patient's details changed? ☐ Yes ☐ No

Title | Given name(s) | Family name | Date of birth (DD/MM/YY)

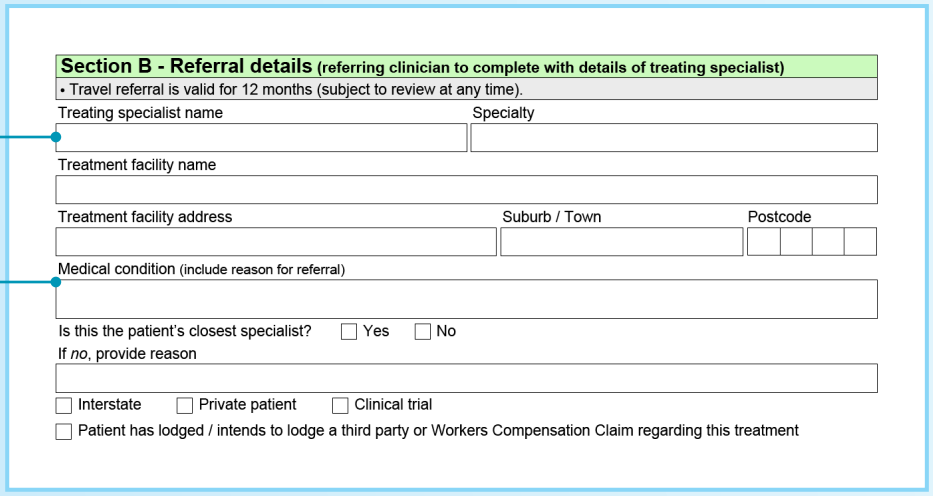
Medicare card number | Expiry date (MM/YY) | Contact number

Section B

2 This section needs to be completed by the clinician referring the patient.

All fields need to be completed.

3 The medical condition section should also include any special conditions which may impact or influence where the patient receives treatment.



Section B - Referral details (referring clinician to complete with details of treating specialist)

• Travel referral is valid for 12 months (subject to review at any time).

Treating specialist name | Specialty

Treatment facility name

Treatment facility address | Suburb / Town | Postcode

Medical condition (include reason for referral)

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

If *no*, provide reason

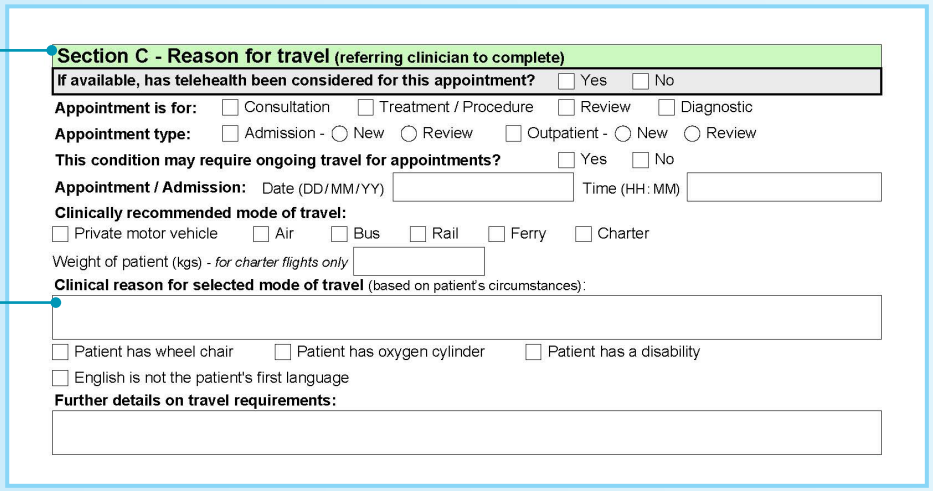
☐ Interstate ☐ Private patient ☐ Clinical trial

☐ Patient has lodged / intends to lodge a third party or Workers Compensation Claim regarding this treatment

Section C

4 This section needs to be completed by the clinician referring the patient. Providing more information will help a more informed decision to be made.

5 Clinical reason for selected mode of travel is important to complete if the patient's travel is restricted such as mobility, disability, health condition etc.



Section C - Reason for travel (referring clinician to complete)

If available, has telehealth been considered for this appointment? ☐ Yes ☐ No

Appointment is for: ☐ Consultation ☐ Treatment / Procedure ☐ Review ☐ Diagnostic

Appointment type: ☐ Admission - ◯ New ◯ Review ☐ Outpatient - ◯ New ◯ Review

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

Weight of patient (kgs) - *for charter flights only*

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

☐ Patient has wheel chair ☐ Patient has oxygen cylinder ☐ Patient has a disability

☐ English is not the patient's first language

Further details on travel requirements:

*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).***

Queensland Government

Section C

6 Further details on travel requirements can also be provided in this section such as accessibility requirements, restrictions to travel based on mode or distance, or if the patient requires assistance when travelling.

Further details on travel requirements:

Section D

7 This section needs to be completed by the clinician referring the patient.

This section should include any further details to support the patient's need for accommodation, including any further accommodation requirements.

Section D - Accommodation (referring clinician to complete)

Is the patient applying for a subsidy for accommodation*?

☐ Yes, private accommodation ☐ Yes, commercial accommodation ☐ Both ☐ No

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

As per the eligibility criteria. Approved by Hospital and Health Service.

Section E

8 This section needs to be completed by the clinician referring the patient.

9 The clinical reason for an escort needs to be completed.

Section E - Patient escort details (referring clinician to complete)

Is the patient applying for a Patient Escort*? ☐ Yes ☐ No

Patient escort details:

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

Clinical reason

Does the patient escort require accommodation?

☐ Yes, same as patient ☐ Yes, different to patient ☐ No

As per the eligibility criteria. Approved by Hospital and Health Service.

Section F

10 Signature to certify information and acknowledgment of possible sharing of information.

Clinician or representative must sign this form as they are providing medical advice relating to the patient.

Section F - Declaration

Referring clinician (or clinicians 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

Contact number | Facility name

Signature | Date (DD/MM/YY)

(Clinician stamp)

*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).***