Government of Western Australia
WA Country Health Service

PATS Verification of Attendance

Department of Primary Industries and Regional Development
GOVERNMENT OF WESTERN AUSTRALIA

TO BE COMPLETED BY THE PATIENT - For every appointment claim

Title		Surname	
Given name(s)			
Address			
Email address			
Contact number		Date of birth	

Accommodation *Eligibility criteria applies and tax invoice/receipt required for commercial.*

Patient
Check In _____ Check out _____ ☐ Private ☐ Commercial
Check In _____ Check out _____ ☐ Private ☐ Commercial

Escort
Check In _____ Check out _____ ☐ Private ☐ Commercial
Check In _____ Check out _____ ☐ Private ☐ Commercial

Travelling via ☐ Private vehicle ☐ Bus/Train *(Invoice/Receipt required)* ☐ Air travel *(Eligibility criteria applies)*
**Air Travel eligibility: trips over 1200km are automatically eligible for air travel (or over 350km if travelling for cancer treatment). Trips under 1200km will require supporting information for flights to be approved, please provide below.*
Departure Date _____ Return Date _____

Patient (or guardian) declaration and consent. I declare that the information provided is true and correct, the expenditure claimed was incurred by me for the reasons outlined here and I am not entitled to claim or recover costs from any other source including compensation, insurance cover or damages. I give consent for WACHS staff to obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care.

Signature		Date	

TO BE COMPLETED BY SPECIALIST OR CLINIC EMPLOYEE – For every appointment claim

To facilitate reimbursement of patient's expenses and/or confirm travel details complete all sections

Appointment date _____ Hospital/Clinic location _____

Specialty _____ Specialist Name _____

Has the patient's condition changed so they require air travel? ☐ Yes ☐ No ☐ N/A
Has the patient's condition changed so they require a support person? ☐ Yes ☐ No ☐ N/A
Has the patient's condition changed so they need to extend their stay? ☐ Yes ☐ No ☐ N/A
Was the patient hospitalised? ☐ Yes ☐ No

Hospital admission date _____ Hospital discharge date _____

If 'Yes' to any of the above, please provide clinical reason:

Stamp	*Practice stamp is required for certification.*	Name	
		Signature	
		Date	

OFFICE USE ONLY PATS Clerk: ☐ Approved ☐ Declined Reference # _____
Delegated Financial Authority: ☐ Approved ☐ Declined Signature/ he #: _____

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST