Government of **Western Australia**
WA Country Health Service

PATS Application/Claim Form

PATS Reference No: _____

ROYALTIES FOR REGIONS

Privacy: WACHS is obliged to validate information provided to assess applications and facilitate subsidy payment and health services. Applicant information is recorded in a secure system. This information is used to provide services to the applicant, communicate related matters and complies with state record keeping and medical requirements.

Section A – TO BE COMPLETED BY PATIENT – Personal Details (new application)
If travel relates to a current application, after visiting your specialist complete the blue patient section only

Title		Surname		Given Name(s)	
Preferred Name					
Date of Birth		☐ Male		☐ Female	Aboriginal/TSI ☐ Yes ☐ No
Residential Address: *(proof may be required)*			Postal address *(if different)*		
Home Phone		Mobile Phone		Email	
Medicare		Number		Expiry	
Pensioner/Concession		Type	Number	Expiry	
Veteran Affairs		Number		☐ Gold ☐ White	

Is this travel related to any of the following? ☐ Motor Vehicle Insurance ☐ Workers Compensation
Please provide claim details

Escort/Guardian name *(if eligible)*	Surname	Given Name(s)

Please select the preferred payment method ☐ EFT ☐ Cheque

Please ensure correct details are provided as PATS will not be responsible for payment losses or fees/charges that may be incurred if incorrect banking details are provided.

6 Digit BSB No: |__|__|__| - |__|__|__| **Account No:** |__|__|__|__|__|__|__|__|

Account Name: _____

SECTION C – TO BE COMPLETED BY PATIENT AFTER SPECIALIST VISIT

Name DOB PATS Reference No

Accommodation – You must provide a receipt for Commercial Accommodation
PATS will not be responsible for any loss or damage incurred during your travel

Patient:	☐☐☐☐☐☐	on / between ☐☐☐☐☐☐	☐ Private	☐ Commercial
	☐☐☐☐☐☐	on / between ☐☐☐☐☐☐	☐ Private	☐ Commercial
Escort:	☐☐☐☐☐☐	on / between ☐☐☐☐☐☐	☐ Private	☐ Commercial
	☐☐☐☐☐☐	on / between ☐☐☐☐☐☐	☐ Private	☐ Commercial

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 WA Country Health Service staff to obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care

Patient/Guardian Signature: Date

WACHS VERSION DATED MAY 2019

THIS IS AVAILABLE IN ALTERNATIVE FORMAT ON REQUEST

SECTION B – REFERRING PRACTITIONER RECOMMENDATION (for completion by referring clinician) ALL FIELDS OF THIS SECTION MUST BE COMPLETED

Can this service be provided via Telehealth? ☐ Yes ☐ No If **No** provide reason:

Does the patient need to be seen urgently (<30 days)? ☐ Yes ☐ No

Is this referral for cancer treatment? ☐ Yes ☐ No | Renal Dialysis? ☐ Yes ☐ No

Cancer treatment means medical specialist treatment which involves surgery, radiotherapy, chemotherapy, immunotherapy and/or palliative intervention. It does not include diagnosis, consultations or treatment planning

REFERRAL DETAILS: *MUST* be to the NEAREST specialist – including telehealth or visiting specialist

Specialist Name	Clinical Speciality	Appointment Date	Time

If **not** the nearest specialist, please provide **clinical details** to support the referral.

Is this referral for radiological purposes? ☐ Yes ☐ No

Please tick: ☐ X Ray ☐ CT Scan ☐ U/S ☐ MRI ☐ Mammography ☐ Nuc Med ☐ PET

Is air travel required? Yes ☐ No ☐ **If YES, clinical reasons must be provided:**

ESCORT RECOMMENDATION: ☐ Yes ☐ No Name _____

Please select reason: ☐ Under 18 ☐ Disability ☐ Frailty ☐ Cancer Treatment

Other (specify a clinical reason) _____

REFERRING PRACTITIONER CERTIFICATION (including stamp)

I certify that the information provided above is complete and correct.

Name: Signature: Stamp

Date:

SECTION C – TO BE COMPLETED BY SPECIALIST OR CLINIC EMPLOYEE

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

The patient received treatment on or between: ____ / ____ / ____ and ____ / ____ / ____

The patient was hospitalised on or between: ____ / ____ / ____ and ____ / ____ / ____

Does the patient require travel home to be upgraded to air travel? ☐ Yes ☐ No

Has the patients' condition changed so they require an escort? ☐ Yes ☐ No

If 'Yes' to any of the above the medical specialist is to stipulate clinical reasons that make air travel and/or an escort essential

Was the patient required to stay overnight? ☐ Yes ☐ No

Does the patient require further treatment? ☐ Yes ☐ No

SPECIALIST NAME *SPECIALITY*

Could the follow up service be provided by Telehealth? ☐ Yes ☐ No

Name: Signature: Stamp

Date:

THIS IS AVAILABLE IN ALTERNATIVE FORMAT ON REQUEST