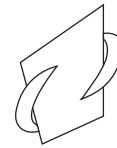




Government of Western Australia  
WA Country Health Service

# 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	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Aboriginal/TSI <input type="checkbox"/> Yes <input type="checkbox"/> No
Residential Address: <i>(proof may be required)</i>		Postal address <i>(if different)</i>	
Home Phone	Mobile Phone	Email	
Medicare	Number	Expiry	
Pensioner/Concession	Type	Number	Expiry
Veteran Affairs	Number	<input type="checkbox"/> Gold <input type="checkbox"/> White	
Is this travel related to any of the following? <input type="checkbox"/> Motor Vehicle Insurance <input type="checkbox"/> Workers Compensation Please provide claim details			
Escort/Guardian name <i>(if eligible)</i>	Surname	Given Name(s)	
Please select the preferred payment method <input type="checkbox"/> EFT <input type="checkbox"/> Cheque <b>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.</b>			
6 Digit BSB No:  _ _ _  -  _ _ _  Account No:  _ _ _ _ _ _ _ _ _ _			
Account Name: _____			

## SECTION C – TO BE COMPLETED BY PATIENT AFTER SPECIALIST VISIT

Name	DOB	PATS Reference No
<b>Accommodation</b> – You must provide a receipt for Commercial Accommodation <i>PATS will not be responsible for any loss or damage incurred during your travel</i>		
Patient: <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> on / between <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/> Private	<input type="checkbox"/> Commercial
<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> on / between <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/> Private	<input type="checkbox"/> Commercial
Escort: <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> on / between <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/> Private	<input type="checkbox"/> Commercial
<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> on / between <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/> Private	<input type="checkbox"/> Commercial
<b>Patient (or guardian) declaration and consent</b>		
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