



1. PERSONAL DETAILS		
Title	Surname	Given Names
DOB ____ / ____ / ____		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
2. REFERRAL DETAILS		
Referral must be to the nearest appropriate eligible specialist (including visiting specialists)		
Specialist Location Regional <input type="checkbox"/> OR Perth <input type="checkbox"/>		
If for clinical reasons the referral is not to the nearest eligible specialist please provide clinical details to support the PATS application. _____		

Is this patient appropriate for Telehealth services? (Videoconference) Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Specialist	Specialty	
Does the patient need to be seen Urgently (<30 days) <input type="checkbox"/> OR Other <input type="checkbox"/>		
Is the eligible specialist medical appointment for Initial Treatment <input type="checkbox"/> OR Follow-up <input type="checkbox"/>		
Is the eligible specialist medical appointment for Inpatient <input type="checkbox"/> OR Outpatient <input type="checkbox"/>		
Is the eligible specialist medical appointment for Consultation <input type="checkbox"/> OR Procedure <input type="checkbox"/>		
Is this referral for cancer treatment? Yes <input type="checkbox"/> OR No <input type="checkbox"/>		
Is this referral for dialysis? Yes <input type="checkbox"/> OR No <input type="checkbox"/>		
3. RECOMMENDED MODE OF TRAVEL		
Does the patient's medical condition require air travel? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does the patient's medical condition warrant the provision of taxi vouchers? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If 'Yes' to above please provide clinical details to support the PATS application.		
4. ESCORT		
Does the patient require an escort? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please Select: Under 18 <input type="checkbox"/> Disability <input type="checkbox"/> Frailty <input type="checkbox"/>		
Cancer treatment <input type="checkbox"/> Medical condition <input type="checkbox"/> Other (please specify) <input type="checkbox"/>		
5. REFERRING MEDICAL PRACTITIONER STAMP / DETAIL AND SIGNATURE		
Name	I certify that I am the referring Medical Practitioner and that the information given is correct.	
Address		
Telephone	Signature	Date
Provider Number		

WA COUNTRY HEALTH SERVICE MEDICAL PRACTITIONER TO COMPLETE



Please submit this PATS form to your PATS Office AS SOON AS POSSIBLE and PRIOR to any travel being undertaken. PATS applications do not grant automatic eligibility to assistance and may take up to ten working days to process.

Residential Address	Postal Address (if different)
---------------------	-------------------------------

Home Phone	Mobile	Work Phone
------------	--------	------------

Email

Preferred Contact
Home Mobile Work Email

Are you a Permanent Country Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Aboriginal / TSI Yes <input type="checkbox"/> No <input type="checkbox"/>
---	---	--

Is this travel related to treatment covered by any of the following?

Workers Compensation <input type="checkbox"/>	Motor Vehicle Insurance <input type="checkbox"/>
Veterans Affairs <input type="checkbox"/>	Employer funded travel <input type="checkbox"/>

Do you have a Medicare Card Number?
Yes No

Do you have a Pensioner, Health Care Concession Card or Commonwealth Seniors Health Care Card? Yes No

6. APPOINTMENT DETAILS

Specialist name and phone number	Appointment date, time and location

7. ESCORT DETAILS (Escort must be a responsible adult over 18 years of age)

Title	Surname	Given Names
-------	---------	-------------

8. RELEVANT TRAVEL NOTES

Please note below any information relevant to your circumstances that needs to be made known to the PATS office undertaking your booking. In the interests of safety, journeys by car over 750km one way are encouraged to be taken over 2 days.

.....

.....

.....

.....

.....

.....

.....

.....

.....

WA COUNTRY HEALTH SERVICE PATIENT TO COMPLETE



9. CONDITIONS OF TRAVEL/ PATIENT / GUARDIAN DECLARATION

Prepaid Flights and Accommodation

If any component of your trip has been prepaid, you must return your PATS Specialist Certification form to the PATS Office. Failure to do this will result in you becoming ineligible for PATS assistance in the future.

Changes to Travel and/ or Accommodation Arrangements:

If for medical reasons you are unable to catch the flight/bus/ train as booked or if you need additional accommodation, you must contact your local PATS office as soon as possible.

Reimbursement of Costs

The PATS Specialist Certification form and receipts for commercial accommodation &/or transport will need to be returned to your local or regional PATS office within eight weeks of your appointment.

Accommodation (is only usually available for 10 days)

If your stay in Perth is known to be in excess of 10 days then you must have this approved PRIOR to your departure. Accommodation can only be approved for a maximum of six months.

I give permission to my Medical Practitioner to provide medical information to the PATS Office to support my application for PATS if required.

Yes No

I understand and accept these conditions and certify that the information above is correct at the time given. I agree that I will repay the WA Country Health Service any cost incurred should I fail to use the pre-booked travel or fail to attend appointments.

Patient / Guardian Signature

Date ____/____/____

If you require further information about PATS please contact

Health Info line 1300 135 030 or www.wacountry.health.wa.gov.au

10. DATE APPLICATION RECEIVED BY PATS OFFICE

WA COUNTRY HEALTH SERVICE PATIENT TO COMPLETE



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

PATS Application Form

**SECTION C
 PATS OFFICE**

Approved / Recommended	YES	NO	Comments
Patient			
Escort			
Accommodation			
Additional Transport Assistance			
Travel Subsidy (please circle)	Fuel Subsidy	Surface Travel	Air 70-100km

The Regional Director or their delegate must approve applications for periods of accommodation in excess of 10 days, but less than six months.

The Regional Specialist or DMO / SMO / Clinical Delegate must approve the PATS application if any of the following circumstances exist. Please indicate if any of these apply and forward application for endorsement or otherwise to the clinical delegate for your area / region.

Referral is to other than the nearest eligible medical specialist <input type="checkbox"/> & / or	Air travel is recommended & trip is less than 16 hours by road ¹ <input type="checkbox"/> & / or	Other exceptional circumstance. <input type="checkbox"/>
--	---	--

11. REGIONAL SPECIALIST / DMS / SMO OR CLINICAL DELEGATE TO COMPLETE

Approved / Recommended	YES	NO	Comments
Patient			
Escort			
Mode of Travel			

Name	Signature
-------------	------------------

Specialist / DMS / SMO / Delegate contacted by phone and verbal advice or approval given

Yes No Signature & Title:

Comments / Notes

.....

Signature of Incurring Officer / Delegated Financial Authority	Date
---	-------------

12. PATIENT NOTIFIED OF OUTCOME PATS OFFICE TO COMPLETE

Notified by
 Phone M W H Message left Spoke to Client
 Email Letter Fax Other

Other Notes

Date	Time	PATS Reference Number	Name and signature of PATS Clerk

WA COUNTRY HEALTH SERVICE PATS OFFICE USE ONLY

¹ With the exception of patients receiving cancer treatment who are required to travel more than 350km by road.