Government of **Western Australia** **WA Country Health Service**	# PATS Patient Details	Department of **Primary Industries and Regional Development**

TO BE COMPLETED BY PATIENT - If you are a new PATS client or to update your details

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

Permanent residential address. Please attach proof of address via; drivers license, health care card, utility bill, lease or mortgage documents, letter from financial institution or letter from employer.

Postal address (if different from above)

If registering a person under 18 please provide details of parent or guardian

Contact Name: ______________________________ Contact Number: ____________________

Medicare Card Number ___ ___ ___ ___ - ___ ___ ___ ___ ___ - ___ ___

Individual reference number ___ ___ Expiry Date ___ ___ - ___ ___ ___ ___

Do you identify as Aboriginal and/or Torres Strait Islander?

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

☐ Neither ☐ Prefer not to say

Preferred reimbursement method ☐ Cheque ☐ Direct deposit (complete below details).

Account Name: ____

6 Digit BSB No: ___ ___ ___ - ___ ___ ___

Account No: ___ ___ ___ ___ ___ ___ ___ ___ ___

PATS is not responsible for payment losses or fees/charges that may be incurred if incorrect banking details are provided.

Do you hold a current pensioner or concession card? ☐ No ☐ Yes (complete below details).
(e.g., Health Care Card, Pensioner Concession Card, Seniors Card)

Type ____

Number ______________________________ Expiry Date ____________________

Veteran Affairs Card ☐ White ☐ Gold (DVA card holders should contact DVA in the first instance).

Number ______________________________ Expiry Date ____________________

OFFICE USE ONLY PATS Clerk: ☐ Approved ☐ Declined Reference # ____________________

Delegated Financial Authority: ☐ Approved ☐ Declined Signature/ he #: ____________________

Privacy: *WA Country Health Service (WACHS) will review and confirm the details you provide to assess your PATS requests. Your information is stored within a secure system. WACHS staff may obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care.*
Further information is provided in the Department of Health Privacy Statement.

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST

PATS Registration & Claim Form

TO BE COMPLETED BY PATIENT – For every appointment claim

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

Is the patient travel urgent? ☐ No ☐ Yes, date required ______________________

Do you require financial assistance prior to your trip? ☐ No ☐ Yes (please indicate what kind below).
☐ accommodation ☐ travel, fuel card ☐ travel, bus/train

Is this travel related to ☐ Motor Vehicle Insurance or ☐ Workers Compensation
Eligibility criteria applies. Statutory declaration required. Please contact your local PATS Office.

Is this appointment related to **cancer treatment** ☐ Yes ☐ No or **renal dialysis** ☐ Yes ☐ No

Appointment Date ______________ **Hospital/Clinic Location** ______________
Specialty ______________ **Specialist Name** ______________
Eligibility criteria applies, must be the nearest specialist including telehealth or visiting specialist.
Please attach **proof of your specialist appointment(s)** (e.g. appointment letter, email, text message).

Travelling via ☐ Private vehicle ☐ Bus ☐ Train ☐ 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 ______________

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

Do you require a **support person** to accompany you on your trip? ☐ Yes ☐ No
Eligibility criteria for support persons applies. Please refer to the PATS Guidelines.
Support person Name ______________ Phone ______________
Reason for support person: ☐ Childbirth ☐ Cancer treatment ☐ Cultural/linguistic support
☐ Journey navigation ☐ Under 18 ☐ Carer ☐ Disability or frail
☐ Other, please specify ______________

Please provide any additional information you think we may need to assess your claim:

(If known) **Referring Practitioner Name** ______________
Practice Name ______________ Phone ______________

Declaration (Patient or Parent/Guardian) 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 accept liability for any obligation to pay fees associated with damages to property or stolen goods claimed by accommodation providers and understand that the WACHS may pursue debts associated with these fees. 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	

OFFICE USE ONLY PATS Clerk: ☐ Approved ☐ Declined Reference # ______________
Delegated Financial Authority: ☐ Approved ☐ Declined Signature/ he #: ______________
Appointment proof via text message sighted ☐ Signature/ he # ______________

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST

Government of Western Australia WA Country Health Service	# PATS Verification of Attendance	Department of Primary Industries and Regional Development

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		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