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

Patient Assisted Travel Scheme (PATS)

Form 2: Verification for PATS Assistance Allied Health and Dental

Important information

- This form confirms attendance for a PATS application. A separate form is needed for each appointment or service attended.
- This form can also be used to clinically support travel requirements (requests/changes) related to a patient's health condition.
- **SECTION A** and **SECTION B** can be completed by patients, clinic employees or clinicians. **SECTION C** must be completed by a treating clinician. **SECTION D** must be completed by a treating clinician or clinic employee.
- Patients need to submit completed forms to PATS. Applications will be impacted if information is missing.

SECTION A Patient details

Surname: _____ **Date of birth:** __ __ /__ __ /__ __ __ __

Given name(s): _____ **URMN** *(if known)*:_____

SECTION B Appointment/ Service details

Date: __ __ / __ __ / __ __ __ __ Time: __ __ : __ __ Specialty: _____

Hospital/ clinic name: _____ Location: _____

Was the patient hospitalised?	☐ Yes - *from:* __ __/__ __/__ __ __ __ *to:* __ __/__ __/__ __ __ __ ☐ No

Has there been a change to the patient's health that requires changes to their travel plans?	☐ Yes – *treating clinician must complete Section C and D* ☐ No – *go to Section D*

SECTION C Health Condition

The patient requires *tick all that apply*

☐ to extend their stay from __ __/__ __/__ __ __ __ to __ __/__ __/__ __ __ __

☐ Air travel

☐ A support person: Reason: _____

Details: Title: _____ Surname: _____ Date of birth: ___/___/_____

Given name: _____ Contact number: _____

Requires: ☐ **Transport:** ☐ Private vehicle ☐ Bus ☐ Train ☐ Air travel

Departure date: __ __/__ __/__ __ __ __ Return date: __ __/__ __/__ __ __ __

☐ **Accommodation:** ☐ Private (*friends/family*) ☐ Commercial (*Hotel, motel ect*)

Check in date: __ __/__ __/__ __ __ __ Check out date: __ __/__ __/__ __ __ __

Provide clinical reason and any additional information:

SECTION D Verification

Clinic stamp (optional)

Private

Name: _____

Email: _____ Number: _____

Signature: _____ Date: __ __/__ __/__ __ __ __

WA Health

HE Number: __ __ __ __ __ __ Signature: _____ Date: __ __/__ __/__ __ __ __

To submit forms, provide feedback or talk to someone

Email: PATS.AHD@health.wa.gov.au *Call: 1800 944 016* *In person:* Regional PATS office