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

PATS Patient Details

Department of
Primary Industries and Regional Development
GOVERNMENT OF WESTERN AUSTRALIA

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