Government of Western Australia
WA Country Health Service

PATS Trip/Claim Form

Department of Primary Industries and Regional Development
GOVERNMENT OF WESTERN AUSTRALIA

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 r**enal dialysis** ☐ Yes ☐ No

Appointment Date _____ **Hospital/Clinic Location** _____
Specialty _____ **Specialist Name** _____
Eligibility criteria applies. Including but not limited to 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