1 PATS Application Form - Section 1 for Local Doctors

Introduction

The Patient Assistance Transport Scheme (PATS) is a subsidy program that provides money to pay for some travel, escort and accommodation costs when people from rural and remote South Australia travel over 100 kilometres each way to see a specialist. More information, including Guidelines for Assessment and brochure, is available at www.sahealth.sa.gov.au/pats

How to apply?

You can make an application online via a dedicated web portal at www.sahealth.sa.gov.au/PATS.

The system makes it easier for your patient to apply for subsidy.

Paper-based application forms can still be submitted via your local PATS office or via Australia Post. The application form is available in three sections:

Section 1 for Local Doctors
Section 2 for Specialists
Section 3 for Patients

To receive a PATS subsidy through Country Health SA Local Health Network by paper, you should complete Section 1 if confirmation of the nearest specialist eligibility is required. After visiting a specialist, who should complete section 2, your patient should then complete and send the relevant sections of the application to the nearest PATS office.

Important information

> PATS travel assistance is intended for patients where specialist services are not available locally, through visiting specialists, or by using telehealth.

> Local doctors are to include a medical reason listed below for escort and air travel subsidy requests.

> For escorts for travel, the criteria includes: impairment, active role or carer, involvement in medical treatment, patient is a child, necessary assistance, or as an alternative to air travel when answering question four.

> For air travel the criteria includes: active clinical management, management of severe pain, urgency, restricted mobility, or life threatening conditions when answering question five.

> Air travel will be subsidised if it is the most economical form of travel.

Collection of personal information

The CHSALHN respects your privacy. Your personal information will be collected, stored, and used for the purposes of administering the Patient Assistance Transport Scheme. Information will not be disclosed unless permitted or required under the *Health Care Act 2008 (SA)* or *Mental Health Act 2009 (SA)*. You may gain access to your personal information stored by the CHSALHN by contacting the Freedom of Information Officer.

Send completed application forms to:

Area Health Service	FAX	Postal Address
Mount Gambier & Districts Health Service	(08) 8721 1555	PO Box 267, MOUNT GAMBIER SA 5290
Port Lincoln Health & Hospital Services	(08) 8683 2060	PO Box 630, PORT LINCOLN SA 5606
Port Augusta Hospital & Regional Health Services	(08) 8668 7643	Hospital Road, PORT AUGUSTA SA 5700
Riverland Regional Health Services	(08) 8580 2498	Maddern Street, BERRI SA 5343
Whyalla Hospital & Health Services	(08) 8648 8529	PO Box 267, WHYALLA SA 5600
Adelaide	(08) 8226 5580	PO Box 3017, Rundle Mall, ADELAIDE SA 5000

For more information

Visit: www.sahealth.sa.gov.au/pats
Email: CHSAPATS@sa.gov.au
Telephone: 1300 341 684

Government of South Australia
SA Health

1 Section 1 – Local Doctor
PATS Application Form

Local doctors are required to authorise questions three to six. Patient/ claimant must not complete this section. Please print using black or blue pen.

Patient Family Name

Date of birth
D D / M M / Y Y Y Y

PATS Client Number
☐ ☐ ☐ ☐ ☐ ☐

Patient Given Names

Medicare Number

Individual Ref. No.
☐

1. Insert local doctor's details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Family name and initial

Provider number

Or stamp below

Practice location

Phone

Email

2. Type of Specialist referred to

Name of Specialist

3. Is the nominated Specialist the nearest Specialist to the patients usual residence?

☐ Yes ☐ No

If no, provide a medical reason why the referral should be to this specialist.

4. Does the patient require an escort during travel?

If yes, include a medical reason explaining why an escort is required to travel with the patient by selecting one of the clinical criteria. Please turn over for clinical criteria.

☐ Yes ☐ No

5. Does the medical condition of the patient warrant air travel?

If yes, include a medical reason explaining why air travel is required by selecting one of the clinical criteria. Please turn over for clinical criteria.

Forward Travel? ☐ Yes ☐ No

Return Travel? ☐ Yes ☐ No

6. Certification by referring local doctor

I certify that the information provided in this section is correct and has been completed by me (or my representative)

Signature of referring local doctor

Date D D / M M / Y Y Y Y

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