Queensland Government

Patient Travel Subsidy Scheme (PTSS)

Travel referral (Form B)

Section A – Patient details (patient or referring clinician to complete)

Has the patient's details changed? ☐ Yes ☑ No

Title:	Given name(s):	Family name:	Date of birth (DD/MM/YYYY):
MISS	DANI	COOPER	21/09/2021

Medicare number:	Expiry date (MM/YY):	Contact number:
		0417275321

Are you of Aboriginal and/or Torres Strait Islander origin?
☑ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Section B – Referral details (referring clinician to complete with details of treating specialist)

- Travel referral is valid for 12 months (subject to review at any time).

Treating specialist name:	Specialty:
DR PREM VENUGOPAL.	CARDIAC SURGICAL TEAM
Treatment facility name:	
CHILDREN'S CARDIAC SPECIALIST CLINIC.	QLD CHILDREN'S HOSPITAL

Treatment facility address:	Suburb / Town:	Postcode:
501 STANLEY ST, [redacted]	SOUTH BRISBANE.	

Medical condition (include reason for referral):
CARDIAC SURGERY

Is this the patient's closest specialist? ☑ Yes ☐ No
If *no*, provide reason:

☐ Interstate ☐ Private patient ☐ Clinical trial
☐ Patient has lodged / intends to lodge a third party or Workers Compensation Claim regarding this treatment

Section C – Reason for travel (referring clinician to complete)

If available, has telehealth been considered for this appointment? ☐ Yes ☐ No

Appointment is for: ☑ Consultation ☑ Treatment / Procedure ☐ Review ☐ Diagnostic
Appointment type: ☑ Admission (☑ New ☐ Review) ☐ Outpatient (☐ New ☐ Review)
This condition may require ongoing travel for appointments? ☑ Yes ☐ No

Appointment / Admission:	Date (DD/MM/YY):	Time (HH:MM):
	30/07/2025	9:30am

Clinically recommended mode of travel:
☐ Private motor vehicle ☑ Air ☐ Bus ☐ Rail ☐ Ferry ☐ Charter

Weight of patient (kgs) - *for charter flights only:*

Clinical reason for selected mode of travel (based on patient's circumstances):
DISTANCE.

☐ Patient has wheel chair ☐ Patient has oxygen cylinder ☐ Patient has a disability
☐ English is not the patient's first language

Further details on travel requirements:
ESCORT - MOTHER OF CHILD

Section D – Accommodation (referring clinician to complete)

Is the patient applying for a subsidy for accommodation*?
☐ Yes, private accommodation ☐ Yes, commercial accommodation ☐ Both ☐ No

Additional information (e.g. clinical reason to stay after appointment or discharge date, accommodation preference, etc.):
RONALD McDONALD HOUSE, SOUTH BRISBANE.
CARDIAC CHILDREN SURGERY

**As per the eligibility criteria. Approved by Hospital and Health Service.*

Section E – Patient escort details (referring clinician to complete)

Is the patient applying for a Patient Escort*? ☑ Yes ☐ No

Patient escort details

Title:	Given name(s):	Family name:	Date of birth (DD/MM/YYYY):
MRS	REBECCA	COOPER	09/05/1987

Clinical reason:
MOTHER OF YOUNG CHILD.

Does the patient escort require accommodation? ☑ Yes, same as patient ☐ Yes, different to patient ☐ No

**As per the eligibility criteria. Approved by Hospital and Health Service.*

Section F – Declaration

Referring clinician (or clinicians nominated representative) declaration:
I certify that the information provided on this form is correct. I have advised the patient or guardian / carer that Hospital and Health Service staff may contact the referring facility and travel / accommodation providers regarding this referral.

Referring clinician / nominated representative name:		*(Clinician stamp)*
Contact number:	Facility name:	
Signature:	Date (DD/MM/YY):	

Hospital and Health Service use only – Approval

Identification number:

Subsidy approved for travel to: ☐ Place of referral ☐ Other: .....
Mode of travel approved: ☐ Private motor vehicle Air ☐ Bus ☐ Train ☐ Ferry ☐ Other
Patient escort approved: ☐ Yes ☐ No
Accommodation approved: ☐ Yes ☐ No
☐ Private accommodation Number of nights approved: Patient: ..... Patient escort: .....
☐ Commercial accommodation Number of nights approved: Patient: ..... Patient escort: .....
☐ HHS to book ☐ Transport ☐ Accommodation ☐ Other: .....

Has it been determined if a telehealth alternative exists for this patient? ☐ Yes ☐ No
If *no*, provide reason:

Hospital and Health Service approval

Approver name:	Signature:	Date (DD/MM/YY):
Approver name:	Signature:	Date (DD/MM/YY):

Special consideration - provide reason:

Application not approved - provide reason:

PTP.pdf
PDF - 357 KB

Queensland Government

Patient Travel Preferences

TRIP ID:_____

Patient First Name: DANI **Patient Surname:** COOPER

Patient Mobile Number: 0417275321 **Patient DOB:** 21/09/21

Pension/Concession Card: — **Expiry:** __/__/__

Patient Postal Address: 5 ARANA DRIVE, RURAL VIEW, QLD 4740

Patient Email Address: rebeccacooper9@hotmail.com

Itinerary to be please tick: **Emailed** ☑ **Posted** ☐ **Picked Up from Travel Office** ☐

Escort First Name: REBECCA *Escort Surname:* COOPER

Escort Mobile Number: 0417275321 *Escort DOB:* 9/5/87

Escort Postal Address: AS ABOVE

Escort Email Address: AS ABOVE.

REASON FOR TRAVEL:

Appointment is for: Consult ☑ **Review** ☐ **Surgery** ☑ **Appointment Date:** __/__/__ **Time:** __

Speciality: CARDIAC - CHILDREN

TRAVEL DETAILS:

Method of Travel please tick: **Flights** ☑ **Bus** ☐ **Train** ☐ **PMV** ☐ MACKAY -> BRISBANE.

Assistance required: Wheelchair ☐ **Oxygen** ☐ **Other:** _____

Departure Date: 29/7/25.

***Please circle* Time:** 6am **Mid-Morning** **Mid Afternoon** **After 4pm**

Returning From: BRISBANE ☑ **TOWNSVILLE** ☐ **OTHER:** _____

Return Date: __/__/__ TBC - surgery.

***Please circle* Time:** 6am **Mid-Morning** **Mid Afternoon** **After 4pm**

ACCOMMODATION has been booked by the Patient at: _____

Check In Date: 04/08/25 **Check Out Date:** 18/08/25.

The Travel Office will only send the Accommodation Confirmation Form for the nights that are clinically required for your trip.

** In keeping with the principle of effective use of resources, costs may be a consideration in deciding on the time of travel. I approve the flights listed above, or the most cost-effective flights to attend my appointment. I understand that any costs associated with any changes/charges to these dates and times that are NOT for medical reasons (proof required from Doctor) must be met by the patient** **Initial** RC

SIGNED: RCooper **Date:** __/__/__

Name: REBECCA COOPER **Relationship to Patient:** MOTHER