Government of **Western Australia**
Department of **Health**

IPTS number

# Interstate Patient Travel Scheme (IPTS)
# Application Form

## Information

This form is used to apply for assistance under the Interstate Patient Travel Scheme (IPTS).

This form is to be completed electronically or manually by the applicant's **Western Australian treating Medical Specialist** on behalf of the patient.

Forms completed by General Practitioners or patients are not accepted.

The IPTS does not cover treatment costs. The IPTS will only provide assistance with travel and accommodation funding for patients to receive approved essential specialist medical treatment that is not available in Western Australia.

Please review the IPTS policy prior to completing this form at healthywa.wa.gov.au/articles/f-i/interstate-patient-transfer-scheme

All bookings are made by the IPTS administrator unless otherwise advised.

**All sections of the form must be completed before the application can be processed.**

Completed forms are to be forwarded to:


Electronically: ipts@health.wa.gov.au

Facsimile: 08 9222 4443

Post: IPTS Administrator
Office of the Chief Medical Officer
Department of Health
2C 189 Royal Street
EAST PERTH WA 6004
(Please allow sufficient time if posting)


The Department of Health is committed to protecting the privacy, confidentiality and security of personal information held in its databases. Information provided in this form will be used only for the purposes of assessment and maintaining contact with applicants. All documentation will be handled in accordance with the *Information Privacy Act 1988* and Department of Health privacy policy and guidelines.

## Patient Details

Title Surname

Full Given Names Date of Birth

Address

UMRN Telephone Mobile

Email

Permanent WA Resident YES NO If not how long have they resided in WA
Health Care or Pension Concessioner Card YES NO
Department of Veterans Affairs YES NO
Medicare Number and Expiry Health Insurance Fund

Has the patient lodged or intends to lodge a third party or workers compensation claim in relation to this treatment YES NO

## Patient Escort

Does the patient require an escort YES NO

**Under 18 years of age:** one escort will automatically be approved. Additional escorts require justification in the box below.

**Over 18 years of age:** one escort may be considered where the patient is at significant medical risk or danger if travelling alone. Please provide justification for escort in the box below.

## Escort Details (Escort must be over 18 years of age)

Title Surname

Full Given Names Relationship to patient

Address

Telephone Mobile

Email

## Patient Clinical Details

Medical condition/s

Treatment to date, including facility/practitioner, treatment type and date provided.

## Details of requested service

Please note that the requested service must not be available in WA and must be covered by a Medicare Benefits Schedule item number. Please review the eligibility criteria in the online Policy Document before proceeding:

Treatment description and MBS item numbers (item numbers not required if funded under the Nationally Funded Centres Program).

Treatment description MBS number

## WA Based Facilities

Please list all WA Facilities/Specialist explored for the service that is now requested. Please provide detailed rationale as to why the WA-based service can not provide the requested service.

Does the patient require special travel requirements? (eg wheelchair for distance, wheelchair and hoist, able to self-toilet, interpreter)

Reason for any anticipated future visits (include number and timeframe).
Future travel will require a new application

Plan for local follow-up

Name of main Specialist/s performing treatment

Telephone, fax and email

Speciality

Name of interstate centre/hospital

Address of interstate centre/hospital

Telephone and fax

Appointment date/s and time

Contact name and phone number of nurse coordinator or treatment centre

## Referring specialist declaration

I am the referring specialist and I certify the information provided is correct:

Full name

Provider number

Speciality

Practice address

Signature

Date

Telephone, fax and email

## Attachment checklist

Please note applications submitted without attachments will be considered incomplete and therefore will not be processed.

- Proof of WA residence for minimum of six months (copy of one of the following: driver's licence, utility bill or lease agreement)
- Photocopy of relevant Concession Card (pensioner, health care concession card, or veteran affairs card)
- Copy of referral letter from treating specialist
- Photocopy of Medicare Card

## Office use only

## CMO Approval

Approval YES NO

Signature

Name

Date

Comments

This document can be made available in alternative formats on request for a person with disability.

Produced by the Office of the Chief Medical Officer
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