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| Patient Travel Subsidy Scheme (PTSS)Repatriation Request (Form E) |
| **Section A – Patient details (patient representative, HHS or specialist to complete)** |
| Title: | Given name(s):      | Family name:      | Date of birth (DD/MM/YYYY):      |
| Date of death (DD/MM/YYYY):       | Place of death (Hospital / Facility name):      |
| Does the deceased identify as being of Aboriginal or Torres Strait Islander descent?:  [ ]  No [ ]  Yes, Aboriginal [ ]  Yes, Torres Strait Islander [ ]  Yes, both Aboriginal and Torres Strait Islander  |
| **Patient escort details** |
| Title: | Full name:      | Date of birth (DD/MM/YYYY):      | Contact number:      |
| Notes:       |
|  |
| **Section B – Evidence**  |
| **Please attach evidence to facilitate transport** |
| [ ]  Life Extinct Form [ ]  Funeral Director invoice for transport [ ]  Other:       |
| Name of Funeral Director:       | Contact details:       |
|  |
| **Section C – Return travel for Escort (if travel not booked, specialist or treating HHS to complete)** |
| **Date ready to travel home** (DD/MM/YY):      |  [ ]  Morning [ ]  Afternoon |
| **Recommended return mode of travel:** [ ]  Private motor vehicle [ ]  Air [ ]  Bus [ ]  Rail [ ]  Ferry |
|  |
| **Section D – Approving hospital details (Home HHS)** |
| Hospital name:       | Contact person:      | Contact number:      |
| Transport authorised to:       |
| Transport details:       |
| Notes:       |
| **Section E – Escort declaration (Patient escort to complete)** |
| *The information provided is true and accurate at the time of application. I give my permission for Hospital and Health Service**staff to obtain information about the deceased patient for the purpose of administering my application. I understand that the family of the deceased patient is responsible for making the transport arrangements with the Funeral Director in consultation with Hospital and Health Service staff. I understand that repatriation is for transportation costs and excludes costs associated with the funeral service.* |
| Escort signature: | Date (DD/MM/YY):      |
|    |
| **Hospital and Health Service use only** *I, as the medical superintendent (or representative), authorise the above transport as required.* |
| Approver name: | Approver signature: | Date (DD/MM/YY): |
|   |