



Appointment attendance (Form C)

Section A - Patient details (patient, HHS or specialist to complete)

Title	Given name(s)	Family name	Date of birth (DD/MM/YY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home hospital	Contact number
<input type="text"/>	<input type="text"/>

Patient escort details:

Title	Full name	Date of birth (DD/MM/YY)	Contact number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Section B - Evidence (specialist to complete)

Part A: Please attach evidence of appointment attendance

Medicare receipt HICAPS receipt Discharge summary

Part B: Please attach evidence of appointment attendance

	Date (DD/MM/YY)	Date (DD/MM/YY)		Date (DD/MM/YY)
Appointment / Admission	<input type="text"/>	<input type="text"/>	Discharge	<input type="text"/>

Complete details or provide stamp:

<p>Specialist name</p> <input style="width: 100%;" type="text"/> <p>Speciality</p> <input style="width: 100%;" type="text"/> <p>Contact name (if not specialist)</p> <input style="width: 100%;" type="text"/> <p>Treatment facility name</p> <input style="width: 100%;" type="text"/> <p>Contact number</p> <input style="width: 100%;" type="text"/> <p>Email</p> <input style="width: 100%;" type="text"/>	<p><i>(Clinician stamp)</i></p>
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I certify that the patient received specialist medical treatment as stated above.

Signature	Date (DD/MM/YY)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name (if not specialist)	Position (if not specialist)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Section C - Return travel (if travel not booked, specialist or treating HHS to complete)

Date ready to travel home (DD/MM/YY)	If not the same day as discharge, provide reason
<input style="width: 100%;" type="text"/> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	<input style="width: 100%;" type="text"/>

Recommended return mode of transport: Private motor vehicle Air Bus Rail Ferry

If *air*, is a commercial flight medical clearance required? Yes No

Section D - Ongoing treatments (specialist to complete)

Has the patient's treatment been completed? Yes No

If *no*, can future appointments be provided via Telehealth? Yes No

Can ongoing treatment be provided at the patient's local hospital? Yes No

Details of next appointment (if further appointments are required - continue in section E, page 2):

Date (approximate / TBA)	Appointment details (name / location)	Patient escort requested	Admission type	Appointment type	Speciality
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Treatment <input type="checkbox"/> Review <input type="checkbox"/> Consultation	<input style="width: 100%;" type="text"/>

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

Clinical reason for selected mode of travel:

Clinical recommendation for escort:

Hospital and Health Service use only	Identification number
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Section E - Additional appointment details (clinician / clinician's nominated representative to complete)

Date	Time (AM/PM)	type	required	required	Signature	Date
Admission		Admission type	Accommodation required	Patient escort required	Clinician declaration	
Date	Time (AM/PM)				Signature	Date
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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