

When to use this form

You may be required to provide referral details to support your online application.

You should use this form if you are submitting an application using our online services and:

- this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service
- you have not submitted a referral for this practitioner or health service in the **last two years**

Air travel

If you need to travel by commercial air, you should get an air approval before you travel. Your practitioner or their authorised representative must contact IPTAAS to get an air approval. You will only get an air approval if you meet the air approval criteria.

Filling in this form

- please use black or blue pen
- print in BLOCK LETTERS
- mark boxes like this with a ✓ or X
- where you see a box like this **Go to question...** skip to the question number shown. You do not need to answer the questions in between.

For more information

Go to our website www.iptaas.health.nsw.gov.au or call us on **1800 IPTAAS (1800 478 227)**.

Part A. Patient details

1. Patient ID (if known)

2. Your name

Title	Given name	Middle name	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Your date of birth

Part B. Referral details

Please read before completing Part B. Referral details.

Part B: Referral details is only required if this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service, or you have not submitted a referral to this practitioner or health service in the last two years.

If required, **Part B: Referral details** is to be completed by your referring practitioner or their authorised representative.

4. Referring practitioner details

Full name	Phone number
<input type="text"/>	<input type="text" value="()"/>

5. Treatment details

Name of practitioner or health service you referred the patient to	
<input type="text"/>	
Treatment location	Type of treatment referred for
<input type="text"/>	<input type="text"/>

6. Is the practitioner or health service the nearest to the patient's residence?

- Yes **Go to question 7**
- No Give details below

Why was the patient not referred to the nearest practitioner or health service?

7. Referring practitioner declaration (to be completed by the referring practitioner or their authorised representative)

Name	Position
<input type="text"/>	<input type="text"/>

I declare that:

- the information provided in Part B is complete and correct

I understand that:

- giving false or misleading information is an offence

Signature <input type="text"/>	Date <input type="text" value="D D/M M/Y Y Y Y"/>
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