



Tseshah First Nation

5091 Tsuma-as Drive, Port Alberni, BC V9Y 8X9 Phone: 250-724-1225 Fax: 778-419-2725

PATIENT TRAVEL REQUEST FORM

Procedures:

1. Please request your doctor's office to fax confirmation of your appointment to the band office.
2. Please fill out ALL SPACES of this form; do not leave any blank spaces. INCOMPLETE FORMS CANNOT BE PROCESSED.
3. Please submit this form with appointment confirmation at least 5 working days prior to your appointment.
4. Have the doctor's office sign/stamp the Confirmation of Attendance Form.

CLIENT INFORMATION:

Name: _____ Band Name: _____

Date of Birth: _____ Status No.: _____
Day Month Year

Care Card No.: _____ Phone No.: _____

Address: _____
Street City Postal Code

Residence: On Reserve Off Reserve

APPOINTMENT INFORMATION:

Referred by: _____ Referral Doctor's Phone No.: _____

Name of specialist: _____ Specialists Phone No.: _____

Specialist Address: _____

Reason for seeing specialist: _____

Appointment Date: _____ Appointment Time: _____ AM / PM

TRAVEL INFORMATION:

ICBC Claim: Yes No Transportation: Bus Car Other: _____

Escort Required: Yes No Reason for Escort: _____

Escort Name: _____ Escort Status No.: _____

Destination: From: _____ To: _____

Departure Date: _____ Time Leaving: _____ AM / PM

Return Date: _____ Return Time: _____ AM / PM

Accommodations Required: No Yes Please book me a hotel Private Accommodations

Terms:

1. 72 hours notice is required for hotel cancellations; if no notice is made, patients are responsible for the hotel expense. To cancel a reservation, please contact the patient travel clerk.
2. Ferry receipts must be submitted to PT clerk – failure to do so will result in ferry reimbursement only.
3. If you cancel or change your appointment, please contact the patient travel clerk.
4. If you miss your appointment for which you have received patient travel, you are responsible to return or repay the patient travel funds; you will not be eligible for future patient travel until you do so.
5. I agree to be responsible for all costs over and above FNHA NIHB patient travel authorization.
6. Cheque issue: 2 pm day before appointment (as long as patient fully completes this form, and submits the form at least 5 business days before appointment, and there are no unforeseen circumstances).

I have read the patient travel terms & procedures, and I agree to abide by them. I confirm that the information provided above is true and correct. Signature: _____ Date: _____