APPLICATION TO CONSULT A PRIVATE HEALTH PRACTITIONER

Under the *Corrections Act 1986* s.47 (1)(f), prisoners in Victoria have "*the right to have access to reasonable medical care and treatment necessary for the preservation of health including, with the approval of the principal medical officer but at the prisoner's own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner.*"

This application form is for a SINGLE CONSULATATION only.

Applications must specify the full name of the private practitioner. If the private health practitioner recommends further consultation or treatment, a new application must be submitted including a treatment plan. Consultations with the Private Health Practitioner must be conducted within six months of approval.

All costs related to the consultation, including any associated transport and/or escort costs or cancellations, are to be paid by the prisoner. Medicare rebates do not apply to prisoners in the state of Victoria.

You are encouraged to CONFIRM these costs BEFORE you submit this application.

Prison management may require that transport/escort costs be paid in advance of the appointment date.

Name of Prisoner ....…………..Prison….……………………………………………………

CRN ……………………………………………….. **D.O.B**……..

I wish to consult (PLEASE CIRCLE ONE OF THE FOLLOWING):

| **Medical Practitioner** | **Dentist** | **Physiotherapist** | **Chiropractor** |

Name of practitioner…………………………………………………………………….. .....…………………………………..

Address………………………………………………………………………….Tel. …………………...…………………..

Reason for application to consult a private health practitioner…………………………………………………………………

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Proposed location of requested consultation: at above address ☐   at prison ☐   via telehealth ☐

Signed…………………………………...………………………..…….. Date………………………………...……..……………………….…...

To be completed by the treating Medical Officer at prison location

Please provide a brief statement /opinion regarding this application

Comments……………………………………………………………………………………….......…………………………………………

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Name of MO at Prison (Print):……………………………….……………Signature of MO at Prison:…………...…………………………………

Does the prisoner understand that ALL costs will be at their own expense?   YES☐   NO☐   Date:…………………..………

This section is to be completed by the Principal Medical Officer, Justice Health

Application Approved*☐   Application **not** Approved ☐

*Approval is subject to the following conditions……………….…………………………………………………………………….

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Name of PMO (Print):……………………….………………Signature of PMO :………...……………………….Date…………,,,,…………