

(All sections must be completed)

**SECTION A- PARTICULARS OF THE PATIENT**

Name of Patient: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth (day/month/year): \_\_\_\_\_ Member No.: \_\_\_\_\_ Policy No.: \_\_\_\_\_

If group insurance, name of the Policyholder: \_\_\_\_\_

**SECTION B - FOLLOW-UP CARE RECOMMENDED BY THE ATTENDING PHYSICIAN**

Diagnosis: \_\_\_\_\_

Confinement Period: \_\_\_\_\_

Recommended Treatment: \_\_\_\_\_

Does the patient need follow-up visit(s)? Yes  No

How many visit(s) is/are required? \_\_\_\_\_

Date of follow-up visit(s): \_\_\_\_\_

Is the patient prescribed with any medicine? Yes  No

Name and dosage of the prescribed medicine: \_\_\_\_\_

Frequency and route of administration: \_\_\_\_\_

Is the prescribed medicine an ongoing treatment? \_\_\_\_\_

Does the patient need Physiotherapy/ Chiropractic/ Acupuncture treatment? (Please circle) Yes  No

Type of treatment needed: \_\_\_\_\_

How many sessions does the patient need? \_\_\_\_\_

Expected completion date of treatment: \_\_\_\_\_

Name of Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

E-mail: \_\_\_\_\_

\_\_\_\_\_  
Signature of Attending Physician with stamp

Date (day/month/year): \_\_\_\_\_