PACIFIC CROSS
VIETNAM

The strength behind your insurance

TREATMENT PLAN FOR CHEMOTHERAPY/RADIOTHERAPY

(All sections must be completed)

PART 1: GENERAL INFORMATION

Insured name: ______________________ Member No.: ______________________

DOB & age: ______________________ Gender: ______________________

PART 2: TREATMENT DETAILS

Please circle: ❑ **CHEMOTHERAPY** ❑ **RADIOTHERAPY**

1. Diagnosis:

____

____

2. The duration of the whole treatment:

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3. Please provide the schedule dates of treatment:

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4. The number of cycles/radiation required:

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5. The medicine and dosage used (if applicable):

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6. Please specify whether it is done on Outpatient or Inpatient basis. For Inpatient, please specific the estimate length of stay:

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7. Estimate cost for each cycle/radiation including hospitalization & Professionals' fee:

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Name of Attending Physician: ______________________

Address: ______________________

____

Tel: ______________________

E-mail: ______________________

____

Signature of Attending Physician with stamp

Date (day/ month/ year): ______________________

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