REFERRAL FOR FOLLOW-UP CARE

(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: _____

_____ _____

Signature of Attending Physician with stamp

Tel: _____

E-mail: _____ Date (day/month/year): _____