TREATMENT PLAN FOR PHYSIOTHERAPY/ CHIROPRACTICE/ ACUPUNTURE

PACIFIC CROSS

(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 Policyholder: _____

SECTION B - TREATMENT PLAN RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis:

_____

Recommended Treatment:

_____

_____

Does the patient need Physiotherapy/ Chiropractic/ Acupuncture treatment? ❑ Yes ❑ No

Type of treatment needed:

_____

_____

How many treatment visits does the patient need?

_____

Expected completion date of treatment:

_____

Does the patient need wound care? ❑ Yes ❑ No

Type of wound care needed

_____

_____

How many visits does the patient required for wound care?

_____

Expected completion date of wound care treatment:

_____

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

How many visit(s) is/are required?

_____

Date of last follow-up:

_____

Name of Attending Physician: _____

Address: _____

_____

Tel: _____

E-mail: _____

_____

Signature of Attending Physician with stamp

Date (day/ month/ year): _____