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PACIFIC CROSS

TREATMENT PLAN
FOR PHYSIOTHERAPY/CHIROPRACTIC/ACUPUNCTURE

(All sections must be completed)

SECTION A – PARTICULARS OF THE EXAMINEE

Name of Patient		Sex
Date of Birth (DD/MM/YY)	Member No.	Policy No.
If group insurance, name of the Policyholder		

SECTION B – TREATMENT PLAN RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis		
Recommended 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		
Does the patient need wound care?	Yes ☐	No ☐
Type of wound care needed		
How many visits does the patient need 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 :

Telephone No. :

E-mail :

Signature of Attending Physician with Stamp

Date: