



REFERRAL FOR FOLLOW-UP CARE

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient		Sex
Date of Birth (MM/DD/YY)	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
<i>Does the patient need follow-up visit(s)?</i> Yes <input type="checkbox"/> No <input type="checkbox"/>
How many visit(s) is / are required?
Date of follow-up visit(s)
<i>Is the patient prescribed with any medicine?</i> Yes <input type="checkbox"/> No <input type="checkbox"/>
Name and dosage of the prescribed medicine
Frequency and route of administration
Is the prescribed medicine an ongoing treatment?
<i>Does the patient need Physiotherapy / Chiropractic / Acupuncture treatment? (Please circle)</i> Yes <input type="checkbox"/> No <input type="checkbox"/>
Type of treatment needed
How many sessions does the patient need?
Expected completion date of treatment

Name of Attending Physician: _____

Address: _____

Telephone No.: _____

Email: _____

Signature of Attending Physician with Stamp

Date: _____