



TREATMENT PLAN FOR PHYSIOTHERAPY / CHIROPRACTIC / ACUPUNCTURE

(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 – TREATMENT PLAN RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis
Recommended Treatment
Does the patient need Physiotherapy / Chiropractic / Acupuncture treatment? (Please circle) Yes <input type="checkbox"/> No <input type="checkbox"/>
Type of treatment needed
How many sessions does the patient need?
Expected completion date of treatment
Does the patient need wound care? Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
How many visit(s) is / are required?
Date of last follow-up

Name of Attending Physician: _____

Address: _____

Telephone No.: _____

Email: _____

Signature of Attending Physician with Stamp

Date: _____