Chase Plaza Tower 19th Floor,
Jl. Jend. Sudirman Kav. 21
Jakarta 12920, Indonesia

PACIFIC CROSS

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* ☐ *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: _____

_____

_____ _____

Signature of Attending Physician with Stamp

Telephone No.: _____

Email: _____ Date: _____

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