PACIFIC CROSS
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REFERRAL FOR FOLLOW-UP CARE

(All Sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name	Date of Birth (MM/DD/YY)	Sex
Address	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	

Does the patient need follow-up visit(s)?	Yes ☐ No ☐
How many visit(s) is / are required?	
Date of follow-up visit(s)	

Is the patient prescribed with any medicine?	Yes ☐ No ☐
Name and dosage of prescribed medicine	
Frequency and route of administration	
Is the prescribed medicine an ongoing treatment?	

Does the patient need physiotherapy /chiropractic / Acupuncture treatment?	Yes ☐ No ☐
Type of treatment needed	
How many sessions does the patient need?	
Excepted completion date of treatment	

Name of attending physician	Address	Telephone No
E-mail:	Signature of attending physician with stamp	
Date:		