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TREATMENT PLAN
FOR CHEMOTERAPHY AND RADIOTHERAPY

(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	

Does the patient need chemotherapy/ radiotherapy?	Yes ☐ No ☐
Duration of treatment	
Schedule date of treatment	
Number of chemotherapy cycle/radiation cycle required	
Name and dosage of prescribed medicine (if applicable)	
Frequency and route of administration	
Please specify length of stay if treatment is received on inpatient basis	
Estimated itemized cost for each chemotherapy cycle/radiation cession including hospital expenses and professional fees	

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