PACIFIC CROSS
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TREATMENT PLAN
FOR PHYSIOTHERAPY/CHIROPRACTICE/ACCUPUNTURE

(All Sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of patient	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	
Recommended 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	

Does the patient need wound care?	Yes ☐ No ☐
Excepted completion date of wound care treatment	
Type of wound care needed	
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	Telephone No
E-mail:	Signature of attending physician with stamp	
Date:		