



## REFERRAL FOR FOLLOW-UP CARE

(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 – FOLLOW-UP CARE RECOMMENDED BY THE ATTENDING PHYSICIAN

Diagnosis
Confinement Period
Recommended Treatment
<i>Does the patient need follow-up visit(s)?</i> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>
How many visit(s) is / are required?
Date of follow-up visit(s)
<i>Is the patient prescribed with any medicine?</i> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>
Name and dosage of the prescribed medicine
Frequency and route of administration
Is the prescribed medicine an ongoing treatment?
<i>Does the patient need Physiotherapy / Chiropractic / Acupuncture treatment? (Please circle)</i> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>
Type of treatment needed
How many sessions does the patient need?
Expected completion date of treatment

Name of Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone No.: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Attending Physician with Stamp*