



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 <input type="checkbox"/> No <input type="checkbox"/>
Type of treatment needed		
How many sessions does the patient need?		
Expected completion date of treatment		
Does the patient need wound care?		Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
How many visit(s) is / are required?		
Date of last follow-up		

Name of Attending Physician: _____

Address: _____

Telephone No.: _____

Email: _____

Signature of Attending Physician with Stamp

Date: _____