PACIFIC CROSS
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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		
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 the prescribed medicine		
Frequency and route of administration		
Is the prescribed medicine an ongoing treatment?		
Does the patient need Physiotherapy / Chiropractic / Acupuncture treatment? (Please circle)	*Yes* ☐	*No* ☐
Type of treatment needed		
How many sessions does the patient need?		
Expected completion date of treatment		

Name of Attending Physician: _____

Address: _____

_____

_____

Telephone No.: _____

Email: _____

_____

Signature of Attending Physician with Stamp

Date: _____

Rev 01/2015