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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* ☐	*No* ☐
Type of treatment needed		
How many sessions does the patient need?		
Expected completion date of treatment		
Does the patient need wound care?	*Yes* ☐	*No* ☐
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* ☐	*No* ☐
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: _____

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