Therapy Treatment Plan

Help us process the claim quickly for our member:

Have you

- ☐ answered all questions?
- ☐ signed and dated the form?

Please send your completed form to:

Upload or secure email via:
axaglobalhealthcare.com/customer

Fax: +44 (0) 1892 508256

Post: International Customer Service
AXA Global Healthcare (UK) Limited, Phillips House, Crescent Road, Tunbridge Wells, Kent, TN1 2PL, UK

1 Patient's details

Name

Membership number/customer number

Patient's date of birth

D D M M Y Y Y Y

Claim number

2 Therapist details

Name

Was the patient referred to you?

- ☐ **No**
- ☐ **Yes** ▶ If yes please give the name of the person who referred the patient?

Therapist type

- ☐ Physiotherapist
- ☐ Chiropractor
- ☐ Osteopath
- ☐ Acupuncturist
- ☐ Homeopath
- ☐ Other, please specify below

Please tick your preferred method of contact

Telephone number ☐

Fax number ☐

Email ☐

Continued on next page

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3 Key clinical findings

Date of diagnosis
(dd/mm/yyyy)

D D M M Y Y Y Y

Please provide details of diagnosis for all conditions you are treating this patient for, including the number of sessions received. What medications (including dosage) is the patient currently prescribed for this condition?

Treatment start date
(dd/mm/yyyy)

D D M M Y Y Y Y

4 Treatment goals

What are the specific improvements expected?

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5 Treatment Plan

Country where treatment is taking place?

Please summarise treatment to date and provide a proposed treatment plan or care pathway and the expected duration of this, including:

- the number of additional sessions being proposed
- any recommendations/ home exercise programmes
- any other relevant information.

Please also attach a copy of the most recent medical practitioner letters if possible.

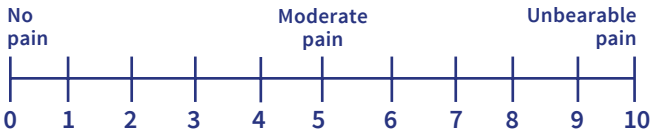
Number of sessions

Duration of each session

Using the VAS scale, what is the patient's level of pain?

Please select

0 – 10 VAS Numeric Pain Distress Scale



What is the patients range of movement?

Does this condition impact on activities of daily living?

☐ **Yes** ☐ **No**

If yes please give details

When will the patient be referred back for Specialist/ Orthopedic review?

D D M M Y Y Y Y

What is the current step down care plan?

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6 Your signature

I am this patient's therapist and confirm the information I have provided is correct to the best of my knowledge. I understand if any of the information is incorrect, this may affect my patient's claim for healthcare expenses.

Signature

Please print name

Date

D D M M Y Y Y Y

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