ONCOLOGY TREATMENT PLAN- CHEMOTHERAPY

PSMAS
PREMIER SERVICE
MEDICAL AID SOCIETY

Name

Membership number ☐☐☐☐☐☐☐☐☐☐☐ **Suffix** ☐☐

Diagnosis

Histology

Stage

Drugs	Dose	Days to be given
1		
2		
3		
4		
5		

Number of cycles planned.....

Duration of each cycle.....

Interval between cycles.....

Any additional therapy.....

Doctor's Name.....

I hereby certify that I,..... Identity number.....

Will be given the treatment stated above. I agree any claim for treatment not given to me will be treated as fraudulent.

Member/Guardian Name (Print).....

Member's/Guardian's Signature.....

STAMP HERE