MY HEALTHCARE CONTACTS

Clear Form

EMERGENCY CONTACT #1

Name: | Relationship:

Address:

City: | State: | Zip:

Phone #1: | Phone #2:

Email:

EMERGENCY CONTACT #2

Name: | Relationship:

Address:

City: | State: | Zip:

Phone #1: | Phone #2:

Email:

I have a living will. ☐ Yes ☐ No Keep a copy in ***My Companion Guidebook*** and give one to your healthcare team.

I have a durable power of attorney (healthcare proxy). ☐ Yes ☐ No

If yes, list Name: | Relationship:

Phone:

My Healthcare Team (You may not have all of these on your healthcare team.)

Medical Oncologist:

Phone: | Fax:

Address: | City: | State: | Zip:

Email: | Portal:

Radiation Oncologist:

Phone: | Fax:

Address: | City: | State: | Zip:

Email: | Portal:

Oncology Nurse:

Phone: | Fax:

Address: | City: | State: | Zip:

Email: | Portal:

Surgeon:

Phone: | Fax:

Address: | City: | State: | Zip:

Email: | Portal:

My Healthcare Contacts continued on next page

Primary Care Provider (Physician Assistant/Nurse Practitioner):

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Pharmacy:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Social Worker:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Navigator/Promotora:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Hospital:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Medical Lab:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Other:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Other:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		