DOC AT YOUR DOOR
Physician House Calls and More

CARE TEAM

Patient Name: _____

Primary Providers	**Name**	**Phone**
☐ Primary Care:	_____	_____
☐ Eye Doctor:	_____	_____
☐ Dentist:	_____	_____
☐ GYN:	_____	_____
☐ Dermatologist:	_____	_____
☐ Hearing:	_____	_____
☐ Podiatry:	_____	_____

Specialty Providers	**Name**	**Phone**
☐ Cardiology:	_____	_____
☐ Endocrinology:	_____	_____
☐ Gastroenterology:	_____	_____
☐ Neurology:	_____	_____
☐ Oncology:	_____	_____
☐ Orthopedics:	_____	_____
☐ Pain Mgt:	_____	_____
☐ Pulmonology:	_____	_____
☐ Renal (Kidney):	_____	_____
☐ Urology:	_____	_____
☐ Therapy (PT/OT):	_____	_____
☐ Other:	_____	_____

Facilities / Personnel / Vendors	**Name**	**Phone**
☐ Preferred Hospital:	_____	(skip)
☐ Home Health Agency:	_____	_____
☐ Caregiver Agency:	_____	_____
☐ Private Caregivers:	_____	_____
	_____	_____
	_____	_____
☐ Care Manager:	_____	_____
☐ Hospice:	_____	_____
☐ Oxygen Supplier:	_____	_____
☐ CPAP Equipment:	_____	_____
☐ Other Equipment:	_____	_____
☐ Medical Supplies:	_____	_____
☐ Medical Transport:	_____	_____
☐ Other:	_____	_____