Marshall Primary Care

# MEDICATION AND SPECIALIST LIST

**Date:** _____ **Date of Birth:** _____

**Last Name:** _____ **First Name:** _____ **MI:** _____

| PROVIDERS INVOLVED IN YOUR HEALTHCARE | |
|---|---|
| **In an effort to ensure optimal care coordination, please list below all providers you see on a regular basis** ***(examples: cardiologist, pulmonologist, endocrinologist, urologist, nephrologist, rheumatologist, neurologist, podiatrist, eye specialist, dentist, oxygen supplier, home health agency or other specialist)*** | |
| **Provider Name** | **Specialty** |
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**Current Medication(s)**

| Medication | Dose | Route (e.g. oral, injection..) | Prescribing Physician |
|---|---|---|---|
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