The Children's Hospital For Rehabilitation THE CLEVELAND CLINIC

HEALTHCARE PROVIDERS

Primary Care Physician:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Neurologist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

The Children's Hospital For Rehabilitation THE CLEVELAND CLINIC

HEALTHCARE PROVIDERS

Pulmonologist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Gastroenterologist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Neonatologist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Psychologist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

The Children's Hospital For Rehabilitation THE CLEVELAND CLINIC

HEALTHCARE PROVIDERS

BCMH Managing Physician:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Physical Therapist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Occupational Therapist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Speech/Language Therapist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

The Children's Hospital For Rehabilitation THE CLEVELAND CLINIC

HEALTHCARE PROVIDERS

Orhotist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Dentist:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Home Care Nursing Agency:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

DME Company:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Service Coordinator:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Waiver Nurse:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Hospital Emergency Department:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Pharmacy:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

HEALTHCARE PROVIDERS

Babysitter:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____

Respite Care Provider:

NAME: _____ Phone/Fax: _____

ADDRESS: _____ Contact Person in the Office: _____

_____ They Take Care of My... _____

_____ _____