

# 1 MY HEALTHCARE CONTACTS

## EMERGENCY CONTACT #1

Name:		Relationship:	
Address:			
City:	State:	Zip:	
Primary #		Secondary #	
Email:			

## EMERGENCY CONTACT #2

Name:		Relationship:	
Address:			
City:	State:	Zip:	
Primary #		Secondary #	
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:		



**Primary Care Provider:**

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:**

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:		