MEDICAL AND REHABILITATION PROVIDER INFORMATION

Use this section to help you remember and stay organized. Make a copy of this list and bring it your appointments.

My Family Doctor:________________________________ Phone __________________
Address: _______________________________________

Specialists:

Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________
Name _______________________ Specialty___________________ Phone __________________

Pharmacist: ____________________________________ Phone __________________
Address: _______________________________________

My Community Rehabilitation Team

Case Manager:

Name_____________________________ Email_________________ Phone __________________

Occupational Therapist:

Name: ____________________________ Email_________________ Phone __________________

Physiotherapist:

Name: ____________________________ Email_________________ Phone __________________

Speech Language Therapist:

Name: ____________________________ Email_________________ Phone __________________

Psychologist:

Name: ____________________________ Email_________________ Phone __________________

Others (e.g. other team members, insurance company, WSIB, lawyer):

Name ____________________________ Phone __________________
Name ____________________________ Phone __________________
Name ____________________________ Phone __________________