

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:		

My Healthcare Contacts continued on next page

© All Rights Reserved
Bag It Cancer 2022



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:		