Life Changes
ELDER CARE CONSULTING LLC

CLIENT HEALTH CARE TEAM

Client Name _____ **Today's date** _____

Name _____ **Specialty PRIMARY CARE PHYSICIAN**

Medical System (circle one):

Work phone _____ **Fax #** _____

Address _____ **City** _____

Electronic Health Record – User ID & Password _____

Name _____ **Specialty DENTIST**

Work phone _____ **Fax #** _____

Address _____ **City** _____

Name _____ **Specialty OPTOMETRIST**

Work phone _____ **Fax #** _____

Address _____ **City** _____

Some examples of Medical Professionals

Internal Medicine Splst
Neurologist
Oncologist
Orthopedic Splst
Dermatologist
Chiropractor/Acupuncturist
Nutritionist
Opthamologies
Gastroenterology
Other

Name _____ **Specialty** _____

Phone _____ **Fax #** _____

Address _____ **City** _____

Name _____ **Specialty** _____

Work phone _____ **Fax #** _____

Address _____ **City** _____

Name _____ **Specialty** _____

Work phone _____ **Fax #** _____

Address _____ **City** _____

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Name _____ **Specialty** _____

Work phone _____ **Fax #** _____

Address _____ **City** _____

PREFERRED PHARMACY

MAIL IN

Name _____ _____

Phone _____ **Fax #** _____

Address _____ **City** _____

LOCAL

Name _____ _____

Phone _____ **Fax #** _____

Address _____ **City** _____

PREFERRED MEDICAL PRACTICE

Name _____ _____

Phone _____ **Fax #** _____

Address _____ **City** _____

PREFERRED HOSPITAL

Name _____ _____

Phone _____ **Fax #** _____

Address _____ **City** _____

INSURANCE

Medicare # _____ **Medicaid #** _____

Other Ins Name _____ **Other ID #** _____

If Medicaid, Social Worker _____

END OF LIFE PLANNING

Funeral Home _____ **Cemetery Plot #** _____

Funeral Arrangements _____