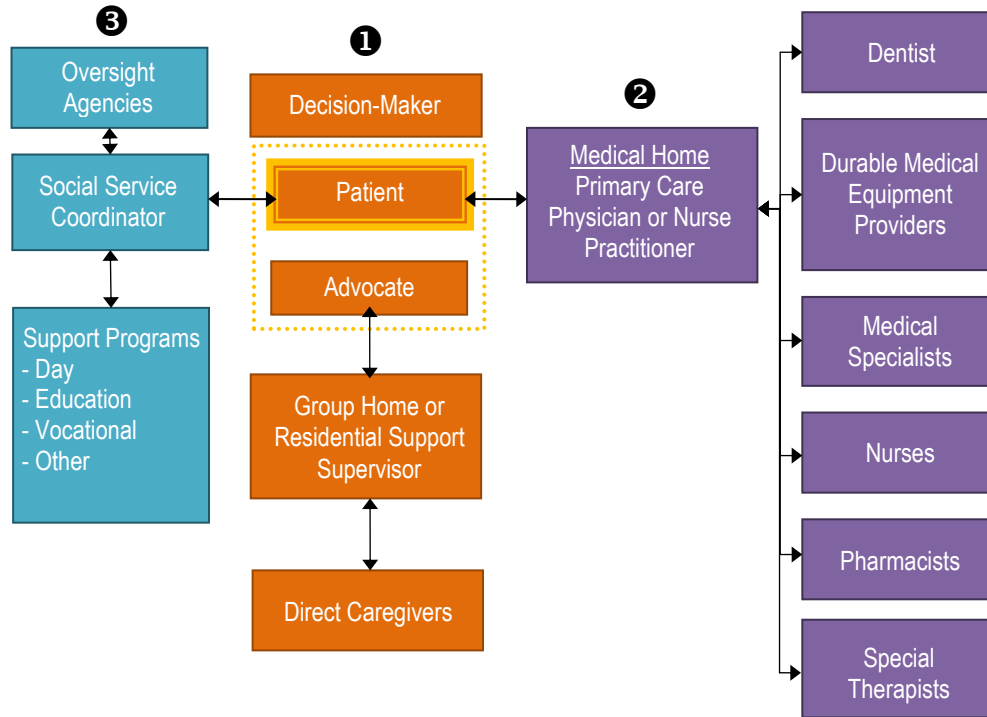




Interdisciplinary Health Care Team Form



1 PATIENT INFORMATION

Name	Needs?	Telephone	Fax	Email	HIPAA Release?
Patient:					<input type="checkbox"/>
Legal Decision-Maker:	<input type="checkbox"/>				<input type="checkbox"/>
Advocate:	<input type="checkbox"/>				<input type="checkbox"/>
Alternate Advocate:	<input type="checkbox"/>				<input type="checkbox"/>
Group Home Supervisor:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>
Primary Family Caregiver:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>
Residential Support Supervisor:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>
Direct Caregiver:					<input type="checkbox"/>

② MEDICAL HOME

Name	Telephone	Fax	Email	HIPAA Release?
Site Name:				<input type="checkbox"/>
Primary Physician/Nurse Practitioner:				<input type="checkbox"/>
Primary Contact:				<input type="checkbox"/>

MEDICAL SPECIALISTS

Name	Telephone	Fax	Email	HIPAA Release?
Doctor: Specialty:				<input type="checkbox"/>
Doctor: Specialty:				<input type="checkbox"/>
Doctor: Specialty:				<input type="checkbox"/>
Doctor: Specialty:				<input type="checkbox"/>
Doctor: Specialty:				<input type="checkbox"/>

PHARMACIST

Name	Telephone	Fax	Email	HIPAA Release?
Pharmacy: Agency:				<input type="checkbox"/>

DENTIST

Name	Telephone	Fax	Email	HIPAA Release?
Provider: Agency:				<input type="checkbox"/>
Primary Contact:				<input type="checkbox"/>

SPECIAL THERAPISTS AND OTHER HEALTH CARE PROVIDERS

Name	Telephone	Fax	Email	HIPAA Release?
Provider: Agency:				<input type="checkbox"/>
Provider: Agency:				<input type="checkbox"/>
Provider: Agency:				<input type="checkbox"/>
Provider: Agency:				<input type="checkbox"/>

DURABLE MEDICAL EQUIPMENT PROVIDERS

Name	Telephone	Fax	Email	HIPAA Release?
Provider: Agency:				<input type="checkbox"/>
Provider: Agency:				<input type="checkbox"/>

3 SOCIAL SERVICES

Name	Telephone	Fax	Email	HIPAA Release?
Social Service Agency:				<input type="checkbox"/>
Case Coordinator:				<input type="checkbox"/>
Oversight Agency:				<input type="checkbox"/>

DAY PROGRAM

Name	Telephone	Fax	Email	HIPAA Release?
Day Program:				<input type="checkbox"/>
Day Program Contact:				<input type="checkbox"/>
Oversight Agency:				<input type="checkbox"/>

EDUCATION

Name	Telephone	Fax	Email	HIPAA Release?
Education Program/School:				<input type="checkbox"/>
Education Program/School Contact:				<input type="checkbox"/>
Oversight Agency:				<input type="checkbox"/>

VOCATIONAL PROGRAM

Name	Telephone	Fax	Email	HIPAA Release?
Vocational Program:				<input type="checkbox"/>
Vocational Program Contact:				<input type="checkbox"/>
Oversight Agency:				<input type="checkbox"/>

OTHER SUPPORT TEAM MEMBER

Name	Telephone	Fax	Email	HIPAA Release?
Program:				<input type="checkbox"/>
Program Contact:				<input type="checkbox"/>
Oversight Agency:				<input type="checkbox"/>