

# Binder Section Suggestions

- Diagnosis
- Speech
- OT
- PT
- Infant Child Development
- Government Funding
- Charity
- IBI Program
- ABA Program
- Respite
- Insurance
- Vision
- RDSP
- Medically Fragile / Complex Care
- Mental Health
-

# Appointment Notes

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Doctor: \_\_\_\_\_

**QUESTIONS**

**NOTES**



# Hospitalization / ER Visit Log

**Date:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Doctor Seen:** \_\_\_\_\_

**Reason:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Discharge:** \_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Therapy Notes

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Therapist: \_\_\_\_\_

**QUESTIONS**

**NOTES**



# CONTACT SHEET -DOCTORS

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

# CONTACT SHEET -THERAPISTS

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Therapist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_