



Family-to-Family Professional Resources Directory

Do you have a *fantastic* physician, an *exceptional* therapist, or an *awesome* attorney you can refer to other families? Let us know! We'll include your referrals in the new Family-to-Family Professional Resources Directory created by families for families, provided free to all members. Questions? Give us a call at 800-400-9994.

Return this form to PWCF at P.O. Box 370085, San Diego, CA 92137 or info@pwcf.org

Your Name _____ Phone _____ Email _____

Advocate Specify Type: Educational Other _____
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Attorney Specify Type: Special Education Expertise Regional Center Expertise Criminal Law Special Needs, Trusts & Wills
Conservatorship within the county of _____
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Behavioral Therapist Pediatric Adult
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Day Program (for adults with PWS)
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Dentist Pediatric Adult
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Ear, Nose & Throat Pediatric Adult
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Endocrinologist Pediatric Adult
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Gastroenterologist
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Geneticist
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Neurologist Pediatric Adult
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Nutritionist / Dietician
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Occupational Therapist
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Optometrist Pediatric Adult Check box if he/she is certified to Provide Vision Therapy
Name _____ Phone _____ Email _____
Address/City/Zip _____ Website _____

Family-to-Family Professional Resources Directory
- Continued from front -

Ophthalmologist

Pediatric Adult

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Orthodontist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Orthopedist

Pediatric Adult Check box if he/she specializes in scoliosis and/or kyphosis Check box if he/she is an Orthopedic surgeon

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Pediatrician or **General Internist** for adults with PWS

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Physical Therapist

Pediatric Adult

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Psychiatrist

Child & Adolescent Adult

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Psychotherapist

Specify type: Marriage & Family Therapist Psychologist Social Worker Drug & Alcohol Counselor Recreational Therapist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Pulmonologist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Sleep Testing/Disorders

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Social Skills Therapist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Speech & Language Pathologist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Urologist

Pediatric Adult

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____

Vocational or Work Site Specify: Privately operated Vocational work site

Company Name _____ Contact _____ Phone _____

Address/City/Zip _____ Located in _____ County

Email _____ Website _____

Other Specialist

Name _____ Phone _____ Email _____

Address/City/Zip _____ Website _____