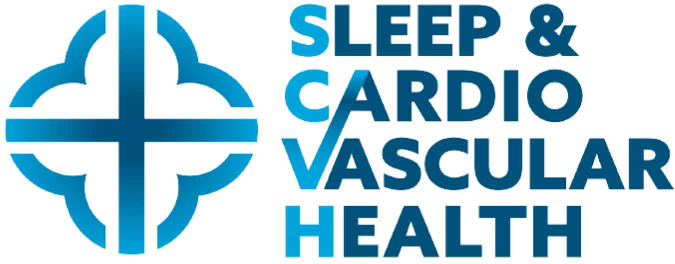

Michael Ledet, MD
Diplomate
American Board of Sleep Medicine & Clinical Lipidology

Sara Welch, PA-C
Diplomate, Clinical Lipidology
Certified Obesity Management

Patient Consultation Request Form

Consultation Requested by: ____

Office Contact Person: ____

Phone: __________________________ Fax: __________________________

_______ Sleep Consultation _______ Lipid Consultation

Provider Concerns: ____
____
____
____

Patient Contact Information

Name: ______________________________________ Date of Birth: ___________________

Email: ______________________________________

Phone Number: ________________________________ ☐ Home ☐ Cell ☐ Work

Requested Information: This information is essential for efficient patient care.

Demographic Sheet	Copy of Insurance Cards
Most Recent Office Note	Complete Medication List
Applicable Lab Results	Cardiac Evaluation Records
Prior Sleep Study	Recent Overnight Oximetry Test

Please fax form and applicable records to 251.278.3930.
Patient Care Coordinator will contact patient to schedule an appointment once all documents have been received.

Patient Contacted: ____________________ LVM _______ LVM _______ Details: _______________

Appt Date: ____________________ Appt Time: ______________ Provider: _______________