Coordinated Care Form

Patient Information

Last name: _____ First name: _____

Phone: _____

SleepWell Solutions will send progress reports, dental records, and copies of your home-based sleep study as appropriate to the doctors that you list below (e.g. primary care physician, dentist, cardiologist, ENT, OB/GYN, etc.). Feel free to list any additional doctors for us to contact.

Physician #1

Last name: _____ First name: _____

Specialty: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Comments: _____

Physician #2

Last name: _____ First name: _____

Specialty: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Comments: _____

Dentist

Last name: _____ First name: _____

Specialty: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Comments: _____

Send to SleepWell Solutions: 6131 Luther Lane, Suite 208, Dallas, TX 75225
Fax to SleepWell Solutions: 214-987-4838