Date: [Date]

To: [Sleep Medicine Specialist Name]
Clinic: [Sleep Clinic Name]
Fax/Address: [Contact Information]

RE: Sleep Medicine Evaluation for Bariatric Surgery Candidacy

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance: [Insurance Provider]

Dear Dr. [Specialist Last Name],

I am referring this patient to your office for a comprehensive sleep evaluation as part of their preoperative workup for bariatric surgery. The patient is currently being evaluated for [Type of Surgery, e.g., Gastric Sleeve/Bypass].

Reason for Referral:

- Screening for Obstructive Sleep Apnea (OSA) per preoperative protocol.
- Assessment of current CPAP compliance and pressure settings (if previously diagnosed).
- Medical clearance for anesthesia and postoperative airway management.

Clinical Findings:

- Current BMI: [Patient BMI]
- Symptoms: [e.g., Loud snoring, daytime somnolence, witnessed gasping]
- Relevant History: [e.g., Hypertension, Type 2 Diabetes]

Please perform the necessary diagnostic testing (Polysomnography or Home Sleep Apnea Test) and provide recommendations for perioperative management. We kindly request a copy of your consultation notes and sleep study results once completed.

Thank you for your assistance in the care of this patient.

Sincerely,

[Referring Physician Signature]
[Referring Physician Printed Name]
[Clinic Name]
[Phone Number]