Date: [Date]

To: [Referring Physician Name]
Address: [Physician Address]
Fax/Phone: [Physician Contact Information]

RE: Patient Consultation

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

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] to our Pulmonology and Sleep Medicine clinic for evaluation of [Primary Complaint, e.g., suspected obstructive sleep apnea, excessive daytime sleepiness].

Clinical History:
The patient reports symptoms including [snoring, witnessed apneas, morning headaches, or non-restorative sleep]. Their Epworth Sleepiness Scale score is [Score]/24. Relevant comorbidities include [BMI, Hypertension, COPD, etc.].

Physical Examination:
On examination, the patient presents with [Mallampati score, neck circumference, and respiratory effort findings].

Assessment and Plan:
Based on the initial consultation, the patient meets clinical criteria for a diagnostic sleep study. We have scheduled the following:

- [ ] Home Sleep Apnea Test (HSAT)
- [ ] In-Lab Polysomnography (PSG)
- [ ] Split-Night Study (if criteria met)

Upon completion of the study, we will review the data to determine the Necessity of CPAP/BiPAP therapy or alternative interventions. A follow-up appointment has been scheduled for [Follow-up Date] to discuss results and initiate treatment.

We will keep you informed of the diagnostic findings and the finalized treatment plan. Please contact our office at [Office Phone Number] if you have any questions.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic Name]