

Date: [Date]

To: [Referring Physician Name]

Address: [Clinic Address]

Fax: [Fax Number]

RE: [Patient Name]

DOB: [Patient Date of Birth]

Date of Consultation: [Appointment Date]

Dear Dr. [Last Name],

Thank you for referring [Patient Name] for a pediatric pulmonary sleep consultation regarding [Reason for Referral/Primary Complaint].

Clinical History:

The patient presents with symptoms including [snoring, witnessed apneas, restless sleep, daytime somnolence, or mouth breathing]. Relevant medical history includes [asthma, tonsillar hypertrophy, neuromuscular disorders, or obesity].

Physical Examination:

On examination, the patient's height is [Height] and weight is [Weight] (BMI percentile: [Percentile]). Notable findings include [Mallampati score, tonsil size 1-4+, nasal obstruction, or chest wall deformities].

Assessment:

[Patient Name] is a [Age]-year-old with clinical features suggestive of [Obstructive Sleep Apnea (OSA) / Periodic Limb Movement Disorder / Sleep Disordered Breathing].

Plan:

1. Schedule an overnight Polysomnogram (PSG) [with/without] CO2 monitoring.
2. [Optional: Initiate intranasal corticosteroids or saline rinses].
3. [Optional: Referral to ENT for evaluation of adenotonsillar hypertrophy].
4. Follow-up appointment in our clinic to review the sleep study results and discuss management.

A formal report of the sleep study findings will be forwarded to your office once completed. Please feel free to contact our office if you have any questions.

Sincerely,

[Doctor Name, MD/DO]

Pediatric Pulmonology & Sleep Medicine

[Facility Name]