

**Date:** [Date]

**To:** [Requesting Surgeon's Name]

**Department:** [Surgical Department]

**Facility:** [Hospital/Clinic Name]

**RE: Pre-Operative Sleep Evaluation**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Proposed Procedure:** [Name of Surgery]

**Surgery Date:** [Date of Surgery]

Dear Dr. [Surgeon's Last Name],

I have completed the pre-operative pulmonology consultation and sleep study evaluation for the above-referenced patient regarding their upcoming procedure.

**Sleep Study Results:**

- **Study Date:** [Date]
- **Diagnosis:** [e.g., Obstructive Sleep Apnea (OSA)]
- **Severity:** [Mild / Moderate / Severe]
- **Apnea-Hypopnea Index (AHI):** [Value]
- **Oxygen Desaturation Nadir:** [Percentage]%

**Current Treatment Plan:**

The patient has been prescribed [CPAP/BiPAP/Auto-PAP] therapy with the following settings: [Settings]. Compliance has been reviewed and is [Adequate/Inadequate].

**Pre-Operative Recommendations:**

- The patient should bring their own PAP device and mask to the hospital on the day of surgery.
- The patient is cleared for surgery from a pulmonary sleep perspective, provided they use PAP therapy during the immediate post-operative period and during sleep.
- Avoid or minimize the use of respiratory-depressant medications (e.g., opioids) when possible.
- Recommend continuous pulse oximetry monitoring for [Number] hours post-extubation.

**Conclusion:**

From a pulmonology standpoint, the patient is [Cleared / Cleared with precautions] for the planned procedure. Please contact my office at [Phone Number] if you have any questions.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

Department of Pulmonology / Sleep Medicine