

Date: [Insert Date]

To: [Recipient Name/Pulmonology Department]

Fax/Address: [Insert Address/Fax Number]

RE: Referral for Sleep Study Consultation

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Insurance: [Insurance Provider & ID Number]

Contact Number: [Patient Phone Number]

Dear Sleep Medicine Specialist,

I am referring this patient for a formal consultation and diagnostic sleep study (Polysomnography) to evaluate for suspected Obstructive Sleep Apnea (OSA).

Clinical Indications:

- History of loud snoring and witnessed apneas.
- Excessive daytime somnolence (Epworth Sleepiness Scale score: [Insert Score]).
- Morning headaches and non-restorative sleep.
- Relevant Comorbidities: [e.g., Hypertension, BMI > 35, Type 2 Diabetes].

Requested Services:

- Initial Pulmonology/Sleep consultation.
- Diagnostic Polysomnography (In-lab) or Home Sleep Apnea Test (HSAT).
- CPAP titration if indicated by study results.
- Follow-up for long-term management.

Please find the patient's recent clinical notes and medication list attached. Please notify my office of the appointment date and the results of the evaluation.

Thank you for your assistance in this patient's care.

Sincerely,

[Referring Physician Name]

[Practice Name]

[Phone Number]

[NPI Number]