Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Referring Provider: [Insert Referring Doctor Name]

Dear [Patient Name],

This letter is to confirm your upcoming consultation with the Pulmonology department regarding an In-Home Sleep Apnea Test (HST). Based on your symptoms and clinical history, your provider has recommended this evaluation to screen for Obstructive Sleep Apnea (OSA) and other sleep-related breathing disorders.

Consultation Details:

- **Appointment Date:** [Insert Date]
- **Appointment Time:** [Insert Time]
- **Location:** [Insert Clinic Address/Room Number]

What to Expect:

During this visit, a clinical specialist will review your respiratory history and provide instructions on how to use the portable sleep monitoring device. You will be sent home with the equipment to perform the study in the comfort of your own bed.

Instructions for the Study:

- Maintain your regular daytime routine.
- Avoid caffeine and alcohol after 2:00 PM on the day of the test.
- Follow the specific device placement instructions provided during your consultation.
- Return the equipment to our office by [Insert Time/Date] the following morning for data download.

Your results will be reviewed by a board-certified Pulmonologist. A follow-up appointment will be scheduled to discuss the findings and potential treatment options, such as CPAP therapy.

If you need to reschedule or have questions regarding insurance coverage for this study, please contact our office at [Insert Phone Number].

Sincerely,

[Doctor Name/Signature]
[Department Name]
[Facility Name]