Date: [Date]

To: [Specialist Name/Pulmonology Department]
Clinic: [Clinic Name]
Address: [Clinic Address]

RE: Referral for Sleep Study Consultation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Contact Number: [Phone Number]
Insurance Info: [Insurance Provider/Policy Number]

Dear Dr. [Specialist Last Name],

I am referring this patient to your care for a formal pulmonary evaluation and a diagnostic sleep study (Polysomnography).

Clinical Indications:
The patient presents with symptoms suggestive of Obstructive Sleep Apnea (OSA) or other sleep-disordered breathing, including:

- Excessive daytime somnolence
- Loud snoring and witnessed apneas
- Morning headaches and non-restorative sleep
- [Additional Symptoms]

Relevant Medical History:
[Brief history of Hypertension, Obesity, COPD, or Cardiac issues]

Current Medications:
[List medications]

Request:
Please perform a consultation and schedule a sleep study (In-lab or Home Sleep Test as clinically indicated). We request a copy of the results and your recommendations for treatment, such as CPAP titration, if applicable.

Thank you for your assistance in the care of this patient.

Sincerely,

[Referring Physician Name]
[Practice Name]
[Phone Number]
[Fax Number]