

Date: [Date]

To: [Pulmonologist Name]

Fax: [Fax Number]

From: [Referring Physician Name]

RE: Medical Clearance for Polysomnography (Sleep Study)

Patient Name: [Patient Name]

Date of Birth: [DOB]

Insurance ID: [ID Number]

Dear Dr. [Pulmonologist Last Name],

I am referring the above-named patient to your clinic for a formal pulmonology consultation and medical clearance for a diagnostic sleep study (polysomnography).

Clinical Indications:

The patient presents with the following symptoms/conditions suggestive of Sleep Disordered Breathing:

- [e.g., Excessive daytime somnolence]
- [e.g., Observed apnea/snoring]
- [e.g., BMI over 35]
- [e.g., Refractory hypertension]

Medical History:

The patient has a history of [List relevant conditions: COPD, CHF, Arrhythmia, etc.]. Current medications include: [List Medications].

Request:

Please evaluate the patient for clinical necessity and safety regarding a sleep study. We request your recommendation on whether a supervised in-lab study or a home sleep apnea test (HSAT) is most appropriate given their pulmonary status.

Please forward your consultation notes and any test orders to our office at [Fax Number].

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Clinic Name]

[Phone Number]