Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Patient ID: [Insert ID Number]

To: [Referring Physician Name]

Subject: Discharge Summary - Chronic Insomnia Clinical Evaluation

Dear Dr. [Last Name],

The patient named above was evaluated on [Evaluation Date] for a clinical assessment of chronic insomnia. This letter summarizes the findings and the recommended management plan upon discharge from this clinic.

Clinical Findings:
The patient reported a history of insomnia lasting [Duration], characterized by [difficulty falling asleep / maintaining sleep / early morning awakening]. Results from the [e.g., Pittsburgh Sleep Quality Index / Sleep Diary] indicate a sleep efficiency of [Percentage]. Physical and psychological screenings [found / did not find] comorbid conditions contributing to sleep disturbances.

Diagnosis:
[Insert Diagnosis, e.g., Chronic Insomnia Disorder (ICD-10 F51.01)]

Treatment Provided:
During the evaluation period, the patient was provided with:
- Sleep hygiene education
- [e.g., Cognitive Behavioral Therapy for Insomnia (CBT-I) sessions]
- [e.g., Pharmacological review/trial]

Discharge Recommendations and Follow-up:
1. Continue [Medication Name and Dosage] as prescribed.
2. Adhere to the established stimulus control and sleep restriction protocol.
3. Follow up with primary care in [Timeframe] to monitor progress.
4. Re-refer to this clinic if symptoms fail to improve or worsen.

Medication Changes:
[List any new prescriptions or discontinued medications]

Thank you for the opportunity to participate in this patient's care.

Sincerely,

[Clinician Signature]
[Clinician Name and Title]
[Department/Facility Name]