[Date]

[Referring Provider Name]
[Clinic/Facility Name]
[Address]
[City, State, Zip]

RE: Discharge from Sleep Medicine Services

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]

Dear Dr. [Referring Provider Last Name],

This letter is to inform you that [Patient Name] has been officially discharged from the Sleep Medicine clinic effective [Discharge Date].

Reason for Discharge:
[Select one: Treatment goals met / Patient stable on long-term therapy / Patient non-compliant with follow-up / Requested transfer of care]

Final Diagnosis:
[Diagnosis, e.g., Obstructive Sleep Apnea]

Treatment Summary:
The patient was managed with [Treatment, e.g., CPAP therapy]. Their most recent data download showed [Results, e.g., excellent compliance and an AHI of 1.2]. The patient reports significant improvement in [Symptoms].

Recommendations for Primary Care:
1. Continue current therapy as prescribed.
2. Renew supplies for [Equipment] as needed.
3. Re-refer to Sleep Medicine if symptoms recur or if there is significant weight change.

We have provided the patient with a copy of their final records. Thank you for the opportunity to participate in this patient's care.

Sincerely,

[Provider Name, Title]
[Clinic Name]
[Phone Number]