Date: [Date]

To: [Referring Physician Name]
Address: [Clinic Address]
Fax/Phone: [Phone/Fax Number]

RE: [Patient Name]
Date of Birth: [Patient DOB]
Date of Evaluation: [Date of Visit]

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] for a pediatric sleep medicine evaluation. I am writing to summarize our findings and the subsequent discharge plan.

Reason for Consultation:
[Insert reason, e.g., Snoring, Daytime Sleepiness, Insomnia]

Clinical Findings:
[Summary of clinical history, physical exam, and sleep study/polysomnogram results if applicable]

Diagnosis:
1. [Diagnosis Name/ICD-10]
2. [Diagnosis Name/ICD-10]

Treatment Provided & Recommendations:
[Summary of interventions, e.g., CPAP therapy, behavioral sleep hygiene, or medication]

Discharge Status:
The patient has met the goals of the sleep medicine consultation. At this time, the patient is being discharged from our specialized sleep clinic back to your primary care for ongoing monitoring.

Follow-up Plan:
[Specify if any future re-evaluations are needed or if the patient should return only if symptoms recur]

If you have any questions or if the patient's condition changes, please do not hesitate to contact our office.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic/Hospital Name]