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

Discharge Summary: Polysomnography & Sleep Evaluation

To: [Referring Physician Name]

Reason for Evaluation:
The patient was referred for a clinical sleep evaluation and overnight polysomnography to investigate symptoms of [e.g., excessive daytime sleepiness, witnessed apnea, snoring].

Study Date: [Insert Date of Study]

Study Findings

- **Sleep Efficiency:** [Insert %]
- **Apnea-Hypopnea Index (AHI):** [Insert Value] events per hour
- **Oxygen Desaturation Index (ODI):** [Insert Value]
- **Lowest Oxygen Saturation (SpO2):** [Insert %]
- **Sleep Architecture:** [Insert brief notes on REM/Non-REM distribution]

Diagnosis

[Insert Diagnosis, e.g., Obstructive Sleep Apnea (G47.33), Restless Leg Syndrome, or Normal Study]

Clinical Summary

[Insert brief narrative of the patient's performance during the study and any significant cardiac or respiratory events noted].

Treatment Recommendations

1. [e.g., Initiation of CPAP/BiPAP therapy at X cmH2O]
2. [e.g., Positional therapy or weight management]
3. [e.g., Follow-up appointment in 4 weeks]
4. [e.g., Referral to ENT or Dental specialist]

Discharge Status:
The patient is discharged from the sleep laboratory following the completion of the diagnostic study. All immediate post-study vital signs were within normal limits.

Sincerely,

[Doctor Name/Signature]
[Board Certified Sleep Physician]
[Facility Name]