Date: [Date]

To: [Recipient Name/Primary Care Physician]
Facility: [Clinic/Hospital Name]
Address: [Address, City, State, Zip]

RE: Transfer of Care / Discharge from Sleep Medicine

Patient Name: [Patient Name]
Date of Birth: [DOB]
MRN: [Medical Record Number]

Dear Dr. [Provider Last Name],

This letter is to formally notify you that [Patient Name] is being discharged from the Sleep Medicine clinic and care is being transferred back to your office for ongoing management.

Initial Diagnosis:
[e.g., Obstructive Sleep Apnea, Insomnia, Restless Leg Syndrome]

Summary of Treatment:
The patient has undergone [Number] months of treatment involving [CPAP therapy/Oral appliance/Medication/Behavioral therapy]. Their condition is currently [Stable/Optimized/Resolved].

Final Diagnostic Results:
[Insert brief summary of most recent Sleep Study or AHI data]

Current Maintenance Plan:
[Specify required medications, device settings, or lifestyle modifications]

Recommendations for Follow-up:
We recommend that the patient continues with [Primary Care Provider] for routine monitoring. We suggest an annual review of [specific symptoms or compliance data]. If the patient experiences a recurrence of symptoms or requires a new diagnostic evaluation, please submit a new referral to our department.

All relevant clinical notes, sleep study reports, and compliance data have been forwarded to your office.

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

Sincerely,

[Provider Signature]
[Provider Name, Title]

[Department Name]
[Phone Number]