[Physician or Clinic Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: Sleep Apnea Mask Fitting and Equipment Compliance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance ID: [Insurance Number]

To Whom It May Concern,

This letter serves to document the mask fitting session and initial compliance status for the above-named patient, who has been diagnosed with Obstructive Sleep Apnea (OSA).

Mask Fitting Details:
A clinical mask fitting was performed on [Date]. The patient was trialed with various interfaces to ensure optimal seal, comfort, and leak reduction. The following equipment was selected:

- Mask Type: [e.g., Nasal, Full Face, or Nasal Pillows]
- Manufacturer/Model: [Insert Model Name]
- Size: [Insert Size]

Compliance and Education:
During the session, the patient received instruction on:

- Proper mask application and strap adjustment.
- Daily and weekly cleaning protocols for the mask, tubing, and humidifier.
- Troubleshooting common issues such as air leaks and skin irritation.
- The importance of using the device for a minimum of 4 hours per night for at least 70% of nights.

Clinical Assessment:
The patient demonstrated proficiency in using the equipment and expressed a commitment to therapy. Regular monitoring of the PAP (Positive Airway Pressure) data downloads will be conducted to track objective compliance and therapeutic efficacy.

Please contact our office at [Phone Number] if further information is required regarding this patient's treatment plan.

Sincerely,

[Signature]

[Printed Name of Clinician]
[Title/Credentials]