Pulmonary Function Test Referral Confirmation

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Referring Physician: [Insert Physician Name]

Facility: [Insert Facility Name]

Dear [Patient Name],

We are writing to confirm your referral for a pulmonary function test. This test is designed to assess your lung function and help us understand your respiratory health.

Test Details:

- **Date of Appointment:** [Insert Appointment Date]
- **Time:** [Insert Appointment Time]
- **Location:** [Insert Testing Facility Address]

Please arrive at least 15 minutes prior to your scheduled appointment. If you have any questions or need to reschedule, do not hesitate to contact our office at [Insert Phone Number].

Thank you for your cooperation.

Sincerely,

[Insert Referring Physician's Name]

[Insert Contact Information]