

Patient Referral Acknowledgment

Date: [Insert Date]

Referring Physician: Dr. [Referring Physician's Name]

Practice Name: [Referring Practice Name]

Address: [Referring Practice Address]

Dear Dr. [Referring Physician's Last Name],

We have received your referral for [Patient's Name] and appreciate your trust in our practice. We are committed to providing the highest quality of care for your patient.

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's DOB]
- Contact Information: [Patient's Contact Info]

We will ensure that [Patient's Name] receives a thorough evaluation and appropriate treatment. We will keep you updated on their progress and any relevant findings.

Thank you for your referral. If you have any questions or need further information, please feel free to contact us.

Sincerely,

[Your Name]

[Your Title]

[Your Practice Name]

[Your Contact Information]