Patient Referral Confirmation

Date: [Insert Date]

To: [Referring Physician's Name]

Address: [Referring Physician's Address]

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

We are writing to confirm the referral of your patient, [Patient's Full Name], to our clinic for evaluation and treatment.

Patient Details:

- **Date of Birth:** [Patient's Date of Birth]
- **Insurance Information:** [Patient's Insurance Provider]

The appointment is scheduled for [Appointment Date and Time] at our office located at [Clinic Address]. Please ensure that the patient brings all relevant medical records and any necessary referral documents.

If you have any questions or require further information, please feel free to contact us at [Clinic Contact Information].

Thank you for your trust in our services.

Sincerely,

[Your Name]

[Your Title]

[Clinic Name]

[Clinic Phone Number]

[Clinic Email Address]