Physician Referral Acceptance

Date: [Insert Date]

[Referring Physician's Name]
[Referring Physician's Title]
[Referring Physician's Practice Name]
[Referring Physician's Address]
[City, State, Zip Code]

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

We have received your referral for [Patient's Name], who was referred for diagnostic evaluation regarding [brief description of the condition or concern]. We appreciate your trust in us for this important assessment.

We will ensure that [Patient's Name] receives comprehensive care and evaluation. Our team will conduct the necessary tests and provide you with a detailed report of the findings and recommendations.

Please feel free to reach out to us if you have any specific concerns or additional information that could assist in the evaluation.

Thank you for your referral. We look forward to working with you and [Patient's Name] to provide the best care possible.

Sincerely,

[Your Name]
[Your Title]
[Your Practice Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]