Physician Referral Acceptance for Surgical Evaluation

Date: [Insert Date]

Dr. [Referring Physician's Name]

[Referring Physician's Practice Name]

[Referring Physician's Address]

[City, State, Zip Code]

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

We are writing to confirm the acceptance of your referral for surgical evaluation of [Patient's Full Name], [Patient's Date of Birth], who was seen in your practice on [Date of Visit].

We appreciate your trust in our services and assure you that we will provide the highest level of care for [Patient's First Name]. Our team will thoroughly evaluate [him/her/them] and will be in contact with you following the evaluation to discuss our findings and recommendations.

Please let us know if there are any specific concerns or information you would like us to consider during the evaluation process.

Thank you for your referral.

Sincerely,

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