

Date: [Insert Date]

To: [Receiving Provider/Facility Name]

Department: [Insert Department]

Fax/Email: [Insert Contact Details]

RE: Referring Clinic Contact Information

Dear [Recipient Name],

Please find the contact information for the referring medical clinic regarding patient [Patient Full Name], DOB: [Patient Date of Birth].

Clinic Name: [Insert Clinic Name]

Primary Physician: [Insert Physician Name]

Office Address: [Insert Street Address, City, State, Zip]

Phone Number: [Insert Phone Number]

Fax Number: [Insert Fax Number]

Email Address: [Insert Email Address]

Office Hours: [Insert Hours of Operation]

Please direct all consultation reports, test results, and follow-up correspondence to the contact details listed above.

Sincerely,

[Your Name/Signature]

[Your Title]

[Clinic Name]