Oncology Referral Alliance Agreement

Date: [Insert Date]

To: [Referring Physician's Name]
[Referring Physician's Address]
[City, State, Zip Code]

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

We are pleased to formalize our collaborative efforts through this Oncology Referral Alliance Agreement. This agreement aims to enhance patient care and streamline communication between our practices.

Terms of Agreement

1. **Referrals:** All oncology referrals will be directed to [Your Practice Name].
2. **Timely Communication:** We commit to providing prompt feedback regarding patient evaluations and recommendations.
3. **Shared Resources:** Both parties will share relevant medical resources and updates.
4. **Patient Care:** Collaborative discussions will be held to ensure optimal patient management.

Duration

This agreement will be valid for a period of [insert duration], starting from the date of signing.

Acceptance

To accept the terms outlined above, please sign below by [Insert Deadline].

Sincerely,

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

_____

Signature of [Referring Physician's Name]
Date: _____