Email: info@arrayskinaz.com
(480) 520-2929

Phototherapy Referral Form

Date _____

Referring Provider _____

Practice Name _____

Provider Tel _____

Provider Fax _____

Patient's Name _____

Patient DOB and Tel _____

DIAGNOSIS: ❑ PSORIASIS ❑ VITILIGO ❑ ECZEMA ❑ ALOPECIA AREATA

❑ CTCL/MYCOSIS FUNGOIDES ❑ MORPHEA ❑ PRURITUS ❑ GRANULOMA ANNULARE

❑ OTHER _____

Additional Information _____

Practitioner's Signature (MD, DO, NP, or PA) _____