(858) 247-0242
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La Jolla, CA 92037

Email: lajolla@arrayskin.com

Phototherapy Referral Form

Date ____________________

Referring Provider ____

Practice Name ____

Provider Tel ____

Provider Fax ____

Patient's Name ____

Patient DOB ____

Patient 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) ____

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