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Suite #295
Scottsdale, AZ 85254

Email: scottsdale@arrayskin.com
Phone: (480)520-2929
Fax: (480)590-5425

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) _____