(801)998-8701
Email: saltlakecity@arrayskin.com

4141 S Highland Drive, Suite 204
Salt Lake City, UT 84124

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) _____