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

11000 N Scottsdale Road, Suite 295
Scottsdale, AZ 85254
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) ____