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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) _____

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