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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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