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Salt Lake City, UT 84124
Email: saltlakecity@arrayskin.com
Phone: (801) 998-8701
Fax: (385) 274-0829

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) _____