PHOTOTHERAPY CLINIC RJH REFERRAL FORM

Memorial Pavilion, 3rd Floor
1952 Bay Street
Victoria, V8R 1J8
Tel: 250-519-1511
Fax: 250-519-1512

Patient Name	
Address	
Home Phone	
Cell / Work Phone	
PHN# or MILITARY#	
DOB (D/M/Y)	

Date of Referral:_____ **Date Reassessment Required:**
(Determined by the Dermatologist) _____

Referring Dermatologist: _____ **Fax:** _____

Family Doctor: _____ **Phones:** _____

PROVISIONAL DIAGNOSIS (*MUST* choose skin type and area of involvement)

Inflammatory Dermatosis:	☐ Atopic Dermatitis ☐ Dermatitis (Non Specific) ☐ Eczema ☐ Pruritis NYD ☐ Other:	**Skin type:** ☐ I ☐ II ☐ III ☐ IV ☐ VI
Photodermatosis:	☐ Polymorphic Light Eruption ☐ Photo Aggravated Eczema	**Area of involvement:** ☐ Body ☐ Palmar ☐ Plantar ☐ Scalp ☐ Eyelids
Psoriasis:	☐ Erythrodermic ☐ Guttate ☐ Inverse ☐ Plaque ☐ Pustular	
	☐ Cutaneous T-Cell Lymphoma(CTCL)/Mycosis Fungoides (Patch stage)	
	☐ Vitiligo	
Other:		

Current Medications	**Allergies**

Other Relevant History & Physical Findings:

****Patients receiving radiation should obtain approval from the Oncologist prior to starting UV treatment ****

Physician Signature:_____ **Date:**_____