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| PHOTOTHERAPY CLINIC RJH REFERRAL FORMSkin Type (I, II, III, IV, V, VI) | Patient Name |  |
| Address |  |
| Home Phone |  |
| Cell / Work Phone | (c) | (w) |
| PHN# |  |
|  DOB (D/M/Y) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Referral |  | Date Reassessment required Determined by the Dermatologist) |  |
| Referring Physician/Dermatologist |  |  | Phone/ Fax |  |
| Family Doctor if different from above |  |  | Phone/ Fax |  |

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| P Provisional Diagnosis  |

 Atopic Dermatitis Psoriasis: erythrodermic, guttate, inverse, plaque, pustular

 Dermatitis other: \_\_\_\_\_\_\_\_\_\_\_\_ Psoriasis: palmar, plantar

 Mycosis Fungoides/CTCL Psoriasis: scalp

 Pruritus Vitiligo

 Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Current Medications |  | **Allergies** |
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| Other Relevant History & Physical Findings:  |  |
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| **Signature** |  | **Date:** |  |

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