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

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| --- | --- | --- | --- | --- | --- | --- |
| 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