PHOTOPHERESIS CONSULTATION REQUEST

Referral to Johns Hopkins Department of Dermatology

Fax this referral to: (410) 955-5322

Telephone: (410) 955-5933

Referring Physician: __________________________

Practice Address: ____________________________________________

Phone: __________________________

Fax: __________________________ Phone: __________________________

Patient Name: __________________________

Patient’s Contact Phone: __________________________

Diagnosis or Suspected Diagnosis: __________________________

Additional Comments: ______________________________________

_______________________________________________________

_______________________________________________________

_______________________________________________________

Thank you for your referral!

Fax this referral to: (410) 955-5322