PHOTOTHERAPY 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: _____________________________ 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