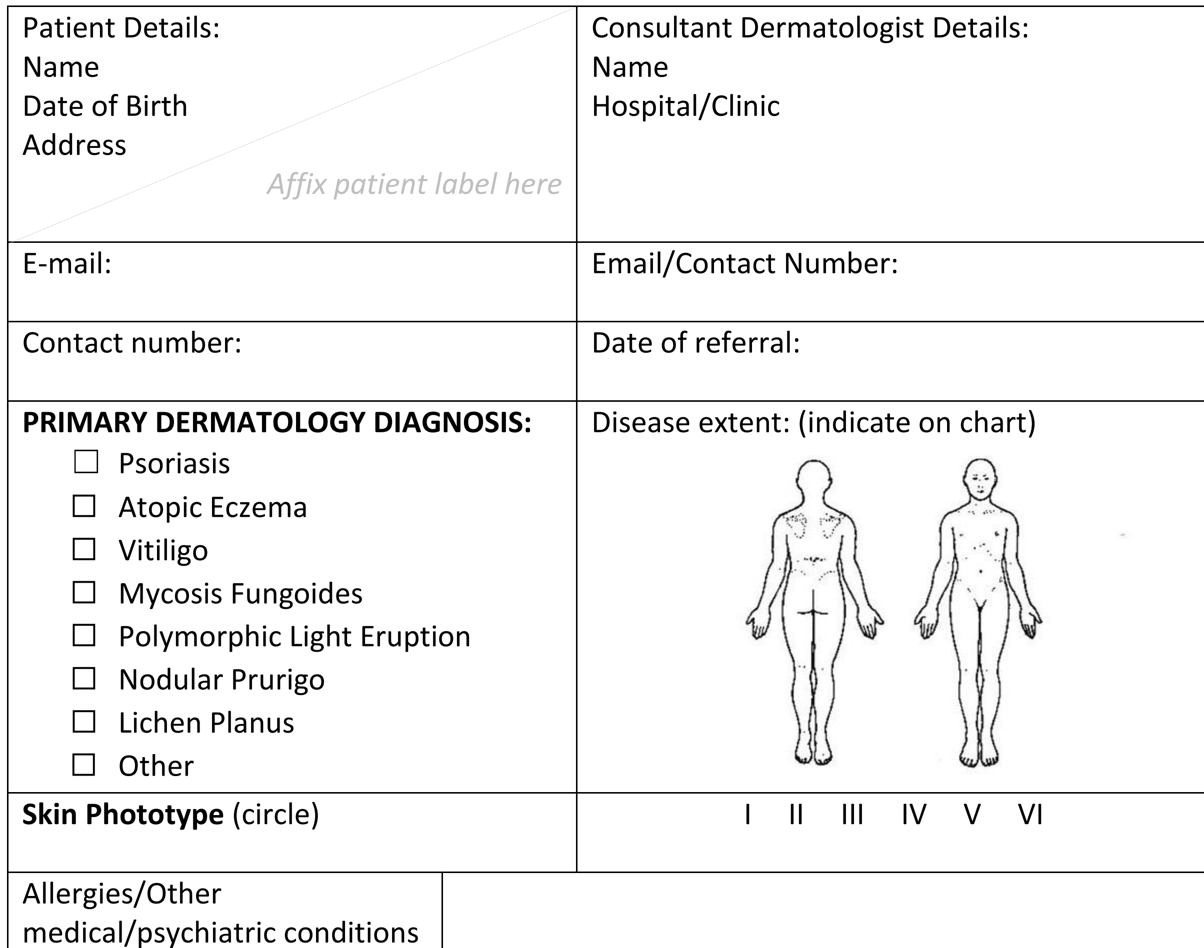
OSD Healthcare

REFERRAL FOR LIGHT THERAPY



Patient Details: Name Date of Birth Address *Affix patient label here*	Consultant Dermatologist Details: Name Hospital/Clinic
E-mail:	Email/Contact Number:
Contact number:	Date of referral:
PRIMARY DERMATOLOGY DIAGNOSIS: ☐ Psoriasis ☐ Atopic Eczema ☐ Vitiligo ☐ Mycosis Fungoides ☐ Polymorphic Light Eruption ☐ Nodular Prurigo ☐ Lichen Planus ☐ Other	Disease extent: (indicate on chart)
Skin Phototype (circle)	I II III IV V VI
Allergies/Other medical/psychiatric conditions	

Area(s) to be treated with NUVB:	☐Whole Body	☐Other (specify)	☐Eyes

Risk/Exclusion Factors	Yes	No	**Risk/Exclusion Factors**	Yes	No
Lupus Erythematosus			H/O PUVA		
Renal/Liver Disease			H/O NUVB		
Immunosuppressant drugs			Regular use of sunbeds		
Cytotoxic drugs			Lived >1 yr in sunny climate		
Photosensitising drugs			Claustrophobia		
Presence of atypical moles			Cold sores		
History of skin cancer			History of photosensitivity		
Current Medication:					
Special instructions: (such as less frequent treatments)					

Sign:	Print:	Date: