REFERRAL LETTER TO

LACOMBE LIGHT THERAPY UNIT

Patient Name _____ Patient DOB _____
Patient AHC _____
Patient Address _____
Patient Phone _____

Dear Dr Van Niekerk,

Please see this patient for their skin condition of _____ to review if narrowband UVB Light Therapy may be of benefit to them.

PMH: List active medical issues here

1. _____ 2. _____

3. _____ 4._____

5. _____ 6. _____

CURRENT MEDICATIONS (include OTC and TOPICAL products)

1. _____ 2. _____

3. _____ 4._____

5. _____ 6. _____

7. _____ 8. _____

ALLERGIES _____

Sincerely yours,

Dr _____