UVBioTek®
The Clear Choice in Skin Treatments™

Doctor's Written Order for Home Narrowband UVB Phototherapy
Phone: 800-882-4683 Fax: 518-747-2294
www.uvbiotek.com

Patient Name: _____ ***Date:***_____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone#: _____ **e-mail** _____

Diagnosis Code: ☐Psoriasis 696.1 ☐Vitiligo 709.1 ☐Eczema 691.8 ☐Other _____

Skin Type Classification: ☐Type I ☐Type II ☐Type III ☐Type IV ☐Type V ☐Type VI

Body Area Affected (Check all that apply)

☐ **3% - 10% (Moderate)** ☐ **Hands (2%)**

☐ **> than 10% (Severe)** ☐ **Feet (2%)**

☐ **Scalp (9%)** ☐ **Other** _____ %

☐ **Cumulate** _____ %

Please provide copy of Prescription and Suggested Treatment Plan to patient

Advise Patient to review UVBiotek.com for model selection and then call 800-882-4683

Prescriber's Signature: _____

Printed Name: _____ **Phone:** _____

Address: _____ **Fax #**: _____

City: _____ **State**: _____ **Zip**: _____

DEA # _____ **NPI #:** _____

This prescription must be submitted with the Suggested Treatment Plan