Photodynamic Therapy (PDT)

Informed Consent Form

Levulan (Aminolevulinic acid 20% is a naturally occurring photosensitizing compound, which has been approved by the FDA to treat pre-cancerous skin lesions called actinic keratosis. Levulan is applied to the skin and subsequently "activated" by a specific wavelength of light. This process of activating Levulan is termed Photodynamic Therapy. The purpose of activating the Levulan is to reduce pre-cancerous skin legions. The treatment may improve the appearance of the skin and other signs of photo aging, decrease acne, reduce sebaceous hyperplasia, decrease oiliness of the skin, and improve texture/smoothness by minimizing pore size. Improvements of these skin conditions (other than actinic keratosis) are considered "off label" use of Levulan.

I understand that Levulan will be applied to my skin. After an incubation time determined by my doctor, the area will be treated with a specific wavelength of light to activate the Levulan. I understand that I should avoid direct sunlight for 48 hours following the treatment due to photosensitivity. I understand that any, even indirect sun exposure during this time, may increase possible side effects including; swelling, burning, redness, and pain. I should wear sunscreen, a hat, and a scarf on my face returning home from this treatment. I must stay home and avoid ANY light from windows for 48 hours and I must diligently use sun protection for 7 days following this treatment.
_____(initial)

Possible side effects of Levulan treatment include discomfort, burning, swelling, redness, and possible peeling, especially in any areas of sun damaged skin a pre-cancers on the skin, as well as lightening or darkening of skin tone and spots. The peeling may last many days and the redness for one week if I have an exuberant response to the treatment. The greater the number of pre-cancers on my skin the more exuberant these reactions will be. _____(initial)

I consent to photographs taken of my face, or location of treatment, before each treatment session. I understand that I may require several treatments spaced 4-6 weeks apart to achieve the optimal results. The recommendations, based on many studies and thousands of patients treated, are 1-2 treatments for AK (actinic keratosis) and 2-4 treatments for acne. Insurance companies may reimburse for AK's of the face and scalp every 90 days. _____(initial)

I understand that medicine is not an exact science, and that there can be no guarantees of my results. I am aware that while some individuals have great results, it is possible that these treatments will not work for me. I understand that alternative treatments include topical medicines, oral medications, cryosurgery, excision surgery, and doing nothing.
_____(initial)

I have read the above information and understand it. The doctor and her/his staff have answered all of my questions satisfactorily. I accept the risks and complications of the procedure. I am not pregnant. By signing this consent form I agree to have one or more Levulan treatments.

Patient Name (Printed) _____ Date: _____

Signature _____

Provider Signature _____ Date: _____