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Photodynamic Therapy (PDT) Consent

Photodynamic therapy (PDT) is a procedure used to treat actinic keratoses (precancerous lesions), certain types of skin cancer, and acne. PDT is FDA-approved to treat actinic keratoses. The purpose of PDT is to create a reaction that destroys only abnormal cells, while leaving normal cells alone.

PDT uses either Levulan (Aminolevulinic acid 20%). This medication is a photosensitizer (medications activated by specific wavelengths of light). It is absorbed into the abnormal cells and then converted into a chemical that makes the cells extremely sensitive to light. When exposed to either red or blue light a reaction occurs which destroys the cells.

It is important to emphasize that no treatment has a 100% success rate and the treated lesions may not resolve or may recur. Another treatment session may be required for maximum results.

As with any procedure, PDT is associated with possible risks and complications. Pain, redness, swelling, blisters, crusting, pigmentation, bruising, worsening of acne, and activation of herpes simplex virus (cold sores) may occur. It is important tell your physician if you are taking any oral medications or using any topical prescription or nonprescription products on the treatment area.

Do not undergo treatment with PDT if you:

- ◆ Have photosensitivity (extreme reaction of skin to sunlight)
- ◆ Have porphyria or sensitivity to porphyrins
- ◆ Are pregnant or breastfeeding

I have read the above information and the informational handout. I have discussed the nature of the proposed treatment, as well as treatment alternatives, with my provider. I have no additional questions. I understand that no guarantee is made regarding a specific outcome of the treatment.

I authorize and consent to the taking of photographs before, during, and after PDT, and at follow-up visits. I understand that photographs are primarily for medical documentation of my treatment. They may also be used for medical education and publication in medical journals. I understand that no identifiable photograph of me will be published without my permission.

Patient Printed Name	Patient Signature	Date
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Witness Printed Name	Witness Signature	Date
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