

**Dermatology Associates Group Laser Center
465 N. Roxbury Drive Suite 801
Beverly Hills, CA. 90210
(310) 274-9954 ext. 227**

LEVULAN PHOTODYNAMIC TREATMENT CONSENT FORM

Levulan (Aminolevulinic acid 20%) is a naturally occurring photosensitizing compound which is used to treat pre-cancerous skin lesions (called actinic keratosis) and to treat acne vulgaris. Levulan is applied to the skin and subsequently “activated” by specific wavelengths of light. This process of activating Levulan with light is termed Photodynamic Therapy. The other purposes of activating the Levulan is to improve the appearance of and reduce acne rosacea, sebaceous hyperplasia, and to decrease oiliness of the skin. The improvement of these skin conditions (other than actinic keratosis) is considered an “off-label” use of Levulan.

I understand that Levulan will be applied to my skin for 1-2 hours depending on the body area. Subsequently, the area will be treated with a specific wavelength of light to activate the Levulan. Following my treatment, I must wash off any Levulan on my skin. I understand that **I must avoid the sunlight for 24 hours following the treatment due to photosensitivity.**

Anticipated side effects of Levulan treatment include discomfort, burning, swelling, redness and possible skin peeling, especially in any areas of sun damaged skin and pre-cancers of the skin, as well as lightening or darkening of skin tone and spots and possible hair removal. The peeling may last many days, possibly several weeks, as a temporary response to treatment.

I consent to the taking of photographs of my face before each treatment session. I understand that I may require several treatment sessions spaced 4-5 weeks apart to achieve optimal results. I understand that I am responsible for payment of this procedure.

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 may experience significant improvements, it is possible that these treatments will not work for me. I understand that alternative treatments include topical medications, oral medications, cryosurgery, excisional surgery or no treatment at all.

I have read the above information and understand it. My questions have been answered satisfactory. I accept the risks and complications of the procedure.

Patient’s Signature

Date

Witness’ Signature

Date

Best phone number to contact you day of appointment: _____

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BLU-U CONSENT FORM

I consent to treatment with Blu-U Light Therapy for the treatment of Actinic Keratoses or Acne Vulgaris. The Blu-U produces a gentle wavelength of light that activated Levulan (an applied topical solution) to penetrate and destroy pre-cancerous lesions, shrink oil glands, and destroy bacteria in the skin. I understand that a series of treatments are necessary (2 – 3 for Actinic Keratoses, 4 -5 for Acne Vulgaris) for optimal improvement, and that continued maintenance treatments are recommended to maintain the benefits.

I understand that no guarantee can be given as to the final result obtained. I am aware that while some individuals may experience significant improvement, it is possible that these treatments may not work for me.

Following treatment, the skin may be reddened and feel like a mild to moderate sunburn. Other side effects of Blu-U with Levulan include mild discomfort, burning, swelling, and possible skin peeling. Hair removal may occur in the treated areas. I understand that, although extremely rare, burning and pigment changes (increases or decreases in skin color). I understand that proper care of the skin following treatment is important and that I must avoid any sun exposure for 24 – 36 hours following the treatment. The treated area should be protected from the sun prior to and during the course of treatments. An SPF30 or higher sunblock lotion should be applied daily and frequently.

I consent to the taking of photographs during the course of my light therapy for the purpose of monitoring the progress of treatment. These photographs will remain in the medical chart and will not be used for any purposes.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the consents of this consent form.

Patient Signature: _____ **Date:** _____

Patient Name: _____
(Please Print)

Witness: _____ **Date:** _____

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Patient Medical History

1. Location of concern (e.g. areas of face, neck) to be treated:

2. Have you ever been treated for this/these problem(s)? Yes _____ No _____
When? _____
What method of treatment? _____

3. Do you have any medication allergies? (Please list) _____
Any skin related allergies? (Please list) _____

4. Do you have a history of HSV (cold sores, fever blisters)? Yes _____ No _____

5. Some medication may increase sun/light sensitivity and/or cause bruising. These include: *Aspirin, Ibuprofen, Anticancer drugs, Antihistamines, Antibiotics, Antidepressants, Diuretics, Antihypertensives, Anti-inflammatory, and Antiparasitics. It is important that you inform the Doctor/RN of any future changes or additions to your medications.*

Please list all current medications, including oral, topical, over-the-counter, and herbal supplements:

_____	_____
_____	_____
_____	_____
_____	_____

Please indicate if you are currently using any of these medications/products:

Retin-A? Yes _____ No _____ if Yes, date of last use: _____

Glycolic Acid? Yes _____ No _____ if Yes, date of last use: _____

Topical Cortisone? Yes _____ No _____ if Yes, date of last use: _____

6. (For Female Patients) Are you pregnant? Yes _____ No _____

7. Have you taken Accutane within the last six months? Yes _____ No _____
If so, when was your last dose? _____
8. Have you had any alcohol in the last 48 hours? Yes _____ No _____
9. Have you had recent sun exposure in the area to be treated?
Yes _____ No _____ If yes, when? _____
10. Do you use self-tanners (“fake tan”)? Yes _____ No _____
If yes, then when was the last application? _____
11. Do you use a sunscreen? Yes _____ No _____
If so, how often do you apply? _____ What is the SPF? _____
12. Have you ever been diagnosed with a disorder associated with photosensitivity
(For example, systemic lupus erythematosus)?
Yes _____ No _____
13. Do you have any cosmetic tattoos/permanent makeup on your face?
Yes _____ No _____ if so, where? _____

Patient Signature: _____ **Date:** _____

Patient Name: _____
(Please Print)

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TOPICAL ANESTHETIC CONSENT

Some patients experience mild to moderate discomfort during the laser treatments. For this reason we offer the use of a topical anesthetic cream. In some instances, the cream may cause a temporary local irritation in individuals who are sensitive to the active ingredients. Although very rare, other more serious side effects can occur. People with a known sensitivity to local anesthetics (Benzocaine, Lidocaine, Tetracaine) should not use this product. If you have been diagnosed with a cardiac or liver condition, take cardiac medication, or are currently pregnant or breastfeeding you should not use this product. This product will not be applied to large surface areas or multiple body sections during a single procedure.

I am choosing to use a topical anesthetic for my laser/light treatment. I have no known allergies/sensitivity to Benzocaine, Lidocaine, or Tetracaine. I understand the potential risks and I have informed the Registered Nurse of my current medical conditions and/or medications.

Patient: _____ Date: _____

Witness: _____ Date: _____

**DERMATOLOGY ASSOCIATES MEDICAL GROUP
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PATIENT CANCELLATION POLICY

DERMATOLOGY ASSOCIATES MEDICAL GROUP LASER CENTER HAS A 24-HOUR CANCELLATION POLICY FOR COSMETIC PROCEDURES. THESE PROCEDURES INCLUDE ALL LASER, INTENSE PULSE LIGHT AND AESTHETIC TREATMENTS.

I UNDERSTAND THAT I WILL BE CHARGED \$100.00 IN THE EVENT THAT MY COSMETIC PROCEDURE APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE.

IN ORDER TO PROVIDE THE BEST POSSIBLE SERVICE TO ALL OF OUR PATIENTS, WE ASK THAT YOU ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME. **LATE ARRIVALS MAY HAVE TO BE RESCHEDULED AND THE CANCELLATION FEE WILL APPLY.**

Patient: _____ Date: _____

Witness: _____ Date: _____

