Patient Name: _____

Patient DOB: _____

Rhode Island Hospital
BROWNHealth
UNIVERSITY

Rhode Island Hospital Photomedicine Unit

Acknowledgment of Consent for Oral PUVA Therapy

I will be receiving Oral PUVA (psoralen + UVA) phototherapy for my skin condition.

1. I will take an oral medication (oral psoralen) prior to each treatment and this medication will make me sensitive to longwave ultraviolet light. Tanning and dryness of the skin are to be expected during my therapy. A reaction similar to a sunburn is a short-term risk of the treatment, and this reaction can be severe if the preventative measures outlined to me are not followed. This includes avoiding further sun or ultraviolet light exposures on the days of my treatment.
2. There are several potential risks of ultraviolet (UV) light exposure:
    a. Cataracts: Exposure to PUVA produces cataracts in animals. This has only rarely occurred in humans, but to minimize the risk I will be required to wear protective glasses before, during and after treatments, and will be obligated to have an eye examination before commencing treatment, and at least yearly thereafter. I will be responsible for arranging these examinations.
    b. Aging of the skin: Repeated and prolonged exposure to UV radiation from the sun induces changes in the skin which appear as premature aging. PUVA therapy will have the same effect. These may include thinning and wrinkling of the skin, freckles, or other dark spots which can occur with long-term therapy.
    c. Skin cancer: The possibility of increased incidence of skin cancer in patients receiving this therapy is of special concern. I have been instructed to report any unusual skin lesions to the doctor and I understand that a complete dermatological examination will be required at least annually while I am receiving treatments and after therapy is discontinued. Actinic keratosis (sun-damaged spots) are also likely to occur with any long-term therapy, especially in areas of previous sun exposure, such as the face. I have been instructed to report any unusual skin lesions to the doctor.
    d. The risk of skin cancer is particularly increased in the genital area, especially in men. I understand that I must shield the genital area during treatment.
3. Nausea, headaches and dizziness have been a problem for some people with oral psoralen. I will notify my doctor or phototherapy nurse if this occurs. I will also notify the phototherapy nurse if I forget to take my medication or take the wrong number of pills.
4. For women of childbearing age, safety of the therapy during pregnancy has not been established and therefore the treatment is NOT recommended during pregnancy. For the same reason, I should take adequate precautions to avoid pregnancy. If pregnancy occurs, I will inform my doctor and the phototherapy nurse immediately.

My conditions and the above procedure have been described to me. Alternative treatments for my condition and the risks of alternative treatment or no treatment have all been explained. I understand that I have and will continue to have opportunities to have my questions answered.

Patient or Legal Guardian Name: _____ Date: _____

Patient or Legal Guardian Signature: _____ Time: _____

I certify that I have fully explained to the above the nature and purpose of Oral PUVA Therapy and the potential risks, benefits, and alternatives to treatment, including no treatment at all and consent has been obtained.

Provider Name: _____ Date: _____

Provider Signature: _____ Time: _____