Patient Name: _____

Patient DOB: _____

Rhode Island Hospital
BROWNHealth
UNIVERSITY

Rhode Island Hospital Photomedicine Unit

Acknowledgment of Consent for UVA Therapy

I will be receiving narrow-band or broad-band ultraviolet A1 (UVA) phototherapy for my skin condition.

1. I understand that there are several potential risks of ultraviolet (UV) light exposure:
    a. Skin Cancer: Repeated and prolonged exposure to ultraviolet light can increase my risk of skin cancer. This includes exposure from natural sunlight, UV phototherapy, PUVA (psoralen + ultraviolet A), or tanning salons. Actinic keratosis (sun-damaged spots) can also occur with any long-term exposure to ultraviolet light. I have been instructed to report any unusual skin lesions to the doctor.
    b. Aging of the skin: Repeated and prolonged exposure to ultraviolet light induces changes in the skin which appear as premature aging. These include thinning and wrinkling of the skin, in addition to freckling.
    c. Injury to the eye: Ultraviolet light can injure my eyes. It is important that I wear protective eye shields (goggles) at all times during my UVB treatment. If I have spots around my eyes that require treatment, I will be specifically instructed how to have that area treated.
2. I understand that a complete dermatological examination will be required at least annually while I am receiving treatment and after therapy is discontinued.
3. Since certain medications can increase my risk of burning from ultraviolet light, I will inform the phototherapy nurse and/or dermatologist if I begin any new medications during the course of my therapy.
4. I should avoid further sun or ultraviolet light exposure on the days of my treatments. If I receive any additional ultraviolet exposure between my UVA treatments, I will inform the phototherapy nurse so that adjustments in my treatment can be made if necessary.
5. Tanning, redness and dryness of the skin are to be expected during my therapy, and are a short term risk of treatment. A blister or burn may possibly occur, which may be severe. Even with all the precautions indicated above, this may still occur at some time during my treatment. I will always inform the phototherapy nurse and/or dermatologist if redness or blistering occurred with the preceding treatment.

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 UVA 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: _____