

Patient Name: _____

Patient DOB: _____



Rhode Island Hospital

BROWNHealth
UNIVERSITY

Rhode Island Hospital Photomedicine Unit Acknowledgment of Consent for UVB Therapy

I will be receiving narrow-band or broad-band ultraviolet B (UVB) 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. 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.
 - c. 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.
 - d. 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 UVB treatments, I will inform the phototherapy nurse so that adjustments in my treatment can be made if necessary.
5. Redness and possible blistering of the skin is a short-term risk of treatment. Even with all the precautions indicated above, this may still occur at some time during my therapy. I will always inform the phototherapy nurse 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 UVB 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: _____