PATIENT CONSENT FOR LEVULANPHOTODYNAMIC TREATMENT

Patient: _____ Date of Birth: _____

Levulan (Animolevulinic acid 20%) is a naturally occurring photosensitizing compound, which has been approved by the FDA and Health and Welfare Canada to treat pre-cancerous skin lesions called actinic keratosis. Levulan is applied to the skin and subsequently "activated" by specific wavelength of light. This process of activating Levulan with light is termed Photodynamic Therapy. The purpose of activating the Levulan is to improve the appearance and reduce acne, rosacea, acne vulgaris, and sebaceous hyperplasia, decrease oiliness of the skin, and improve texture and smoothness by minimizing pore size. Any pre-cancerous lesions are also simultaneously treated. 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 30-90 minutes. 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 should avoid direct sunlight for 48 hours following the treatment due to photosensitivity. I understand that I am not pregnant.

I understand that if I have a history of fever blisters, I will make the nurse aware prior to my treatment so that I can be treated prior to my treatment as a precaution

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 days, and the redness for several weeks if I have an exuberant response to treatment similar to a severe sunburn.

I consent to the taking photographs of my face before each treatment session. I understand that I may require several treatment sessions spaced 2-4 weeks apart to achieve optimal results. I understand that I am responsible for payment of this procedure as it may not be covered by health insurance.

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 have fabulous results, it is possible that these treatments will not work for me. I understand that alternative treatments include topical medications, oral medications, cryosurgery, excisional surgery, and doing nothing.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I have read the above information and understand it. My questions have been answered satisfactory by the doctor and her staff. I accept the risks and complications of the procedure. By signing this consent form I agree to have one or more Levulan treatments.

_____	_____	_____
Patient Signature	Staff/Provider	Date

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