New England Dermatology & Laser Center
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INFORMED CONSENT: LEVULAN PHOTODYNAMIC TREATMENT

Levulan is a naturally occurring photosensitizing compound which has been approved by the FDA to treat precancerous skin lesions called actinic keratosis. 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. This treatment can be given to improve acne, actinic keratoses, photoaging of the skin, and other skin conditions. 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. Subsequently, the area will be treated with a specific wavelength of light to activate the Levulan. Following my treatment, I must wash off the Levulan. I understand I must avoid direct sunlight and other intense light sources for 48 hours following treatment, wear a wide brimmed hat, and apply sunblock with SPF 30 or greater containing titanium dioxide and/or zinc oxide. I am not pregnant.

I have been given and have read the pre- and post-treatment patient information guide. Possible side effects of Levulan treatment include but are not limited to discomfort, burning, swelling, redness, scaling, blistering, and crusting, which may last several days to several weeks. Lightening or darkening of skin tone in spots and hair removal are possible.

I consent to the taking of photographs if requested. I understand that I may require several treatment sessions spaced 2-6 weeks apart to achieve optimum results. Unfortunately, medicine is not an exact science and no guarantees or assurances can be given that my expectation will be met. I understand that alternative treatments are available and these have been discussed as well.

I understand that I am responsible for payment of this procedure if it is not covered by my insurance.

I have read the above information, as well as the "Blu-U Levulan Patient Information" and understand it. My questions have been answered satisfactorily by my provider and/or his/her staff. I accept the risks and possible complications of the procedure. By signing this consent form I agree to have one or more Levulan/light treatments.

_____ _____

Signature (Guardian, if applicable)

_____

Name

_____ _____

Date Witness