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INFORMED CONSENT
BLUE-RED LIGHT/LEVULAN PHOTODYNAMIC THERAPY (PDT)

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 authorize my provider _____ and/or, his/her, associates/staff, to perform PDT in an

effort to improve my _____.

I understand that Levulan may 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 zinc oxide and/or titanium dioxide. I am not pregnant. I have not taken any oral medications for 5 days or applied any topical medications for 2 days which could make me more sensitive to light. I do not have a light sensitive skin disease (lupus, porphyria, etc.).

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 and diminished hair growth in the treatment area is possible.

I consent to the taking of photographs if requested. I understand that I may require several treatment sessions spaced 2-8 weeks apart to achieve optimum results. Furthermore, results are not likely to be permanent and periodic treatments may be necessary to maintain 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 "Blue-Red Light 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