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Photodynamic Therapy CONSENT FORM

Please read and initial each statement.

I have read the “**Photodynamic Therapy Information and Treatment Instructions sheet**” and have had an opportunity to ask questions about the procedure and treatment and had my questions answered satisfactorily.

I authorize the physician, nurse or laser technician to perform Photodynamic Therapy on me.

The cost of the procedure(s) has been discussed with me and I agree to pay this amount.

I understand:

- the goal of PDT is the gradual improvement of skin tone not texture. Every individual is unique and it is very difficult to guarantee the specific number of treatments needed. Results vary with the individual depending on skin colour, degree of sun damage or skin condition being treated. It is expected that I will require **3 to 4 treatments**.
- expected side effects such as a **sunburn-like sensation, prickling or stinging** may occur during treatment. Following treatment, **redness and swelling** of the treated lesions and surrounding skin may occur. This usually subsides significantly within the first week and resolves within 4 weeks. Rarely, **blistering, infection and scarring** may occur whenever a skin procedure is performed. **Pigment changes** of freckles, moles or skin such as **hypopigmentation (lightening)** or **hyperpigmentation (darkening)** usually resolves in 3 to 6 months but can be permanent. There may be risks not yet known at this time.
- eye damage can occur if protective eyewear is not worn.
- many of these side effects are worsened by intentional or accidental sun exposure and use of a good quality SPF daily is very important and highly recommended.

- there may be an increased occurrence of side effects if I do not follow Photodynamic Therapy Information and Treatment Instructions sheet. _____
- there are other options for treatment including not having the procedure. _____
- PDT treatments are **not recommended** if you are pregnant or breastfeeding, if you have an active infection at the site, if you are taking photosensitizing mentioned in the PDT Information and Treatment Instructions sheet, have an unwillingness to wear SPF products, tattoos in the area to be treated, a history of light sensitive seizures, keloid formation or have melasma. None of these conditions apply to me or if they do I realize I am at increased risk of side effects or complications. I will inform the nurse of physician if my medical condition changes over the course of treatment. _____
- the risk of side effects increases with other medical conditions such as immunocompromised conditions (diabetes, HIV, being on immune suppressants such as prednisone) that can be associated with poor skin healing and increased risk of infection. None of these conditions apply to me or if they do I realize I am at increased risk of side effects or complications. _____
- every person is unique and although good results are expected, it is impossible to guarantee. _____
- I should call the clinic if I have any questions about my treatment. _____

I authorize the taking of clinical photographs for:

- my clinic record _____
- research and education (discretion applied) _____
- publication _____
- the U Cosmetic website (discretion applied) _____
- the U Cosmetic Brag Book kept in the clinic (discretion applied) _____

I have read and understood this **Photodynamic Therapy Consent Form**. My questions have been answered satisfactorily by the doctor, nurse or laser technician. I accept the risks and complications of the procedure.

Patient name (please print) Date Signature

Witness name (please print) Date Signature

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