



PHOTOTHERAPY
 PHYSIOTHERAPY DEPARTMENT
 BON SECOURS HOSPITAL
 College Road, Cork.
 Tel 021-4801630 Fax 021-4542137

PHOTOTHERAPY TREATMENT REFERRAL

Name : _____	MRN _____
Address: _____	D.O.B. _____
_____	Telephone No: _____
_____	_____

Date of Referral: _____

Consultant: _____

Diagnosis: _____

UV Treatment: TL-01 / UVA hand and foot

Skin Type (Please Circle)

- | | |
|-------------------------------|-----------------------------|
| 1. Always Burn/Never Tan | 4.4. Never Burn/Always Tan |
| 2. Usually Burn/Sometimes Tan | 5.5. Asian Subjects |
| 3. Sometimes burn/Usually Tan | 6.6. Black African Subjects |

Previous History:

Photosensitivity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin Cancers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
CVS/hepatic/ renal disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Allergies _____

 Medical History _____

 Previous Skin surgery _____

Precautions

UVB (broadband)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
UVB (TLO1)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PUVA	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lived Abroad	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sunbed use	Yes <input type="checkbox"/>	No <input type="checkbox"/>

MXT	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Retinoids	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cyclosporin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Radiotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pregnancy(PUVA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Exclusion Factors

Less than 10 years old	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lupus erythematosus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Genophotodermatoses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Photo-induced epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current Drugs

Oral: _____

 Potential Photosensitisers: _____

 Current Topical Therapy: _____
 Potential Photosensitisers: _____

Doctor's Signature _____

CONSENT TO PHOTOTHERAPY

Patients Name : _____	MRN _____
Address: _____	D.O.B. _____
_____	Telephone No: _____

I UNDERTAKE TO ADHERE TO THE FOLLOWING GUIDELINES, THROUGHOUT THE COURSE OF TREATMENT

1. Avoid any other form of ultra-violet light, eg. Sunbed or sunbathing during the treatment course.
2. Tell the Doctor or Physiotherapist if I commence a new course of tablets or creams, prescribed, purchased from a pharmacy or an alternative practitioner
3. Avoid perfumes, aftershave or other cosmetics on days of UV treatment.
4. Avoid significant alcohol intake on days of treatment.
5. If male, shield my genitalia with a G string while in the UV cabinet which is provided.
6. Protect my eyes during treatment with the protective goggles provided.
7. Wear protective face shield as advised
8. Attend 2 / 3 days per week as requested by Doctor.

You may experience pinkness of the skin 6 -24 hrs post UVB and up to 48 hrs post PUVA. If however the skin feels sore or you are unsure about your skin please ask **BEFORE** the next treatment is given.

Prolonged and repeated courses of phototherapy may lead to an increased risk of developing skin cancer. This risk is initially very small. The lifetime limit for narrowband UVB is 500 treatments. For PUVA the lifetime limit is 150 treatments.

I understand that after months of treatment UV may accelerate skin ageing and be associated with an increased risk of skin cancer.

I confirm that the nature and risks of UV therapy have been explained to me by
Dr. _____

Signature of Patient _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

Signature of Doctor _____ **Date** _____

