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

PHOTOTHERAPY TREATMENT REFERRAL

Name :_____ Address:_____ _____ _____	MRN_____ 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
2. Usually Burn/Sometimes Tan
3. Sometimes burn/Usually Tan
4. 4. Never Burn/Always Tan
5. 5. Asian Subjects
6. 6. Black African Subjects

Previous History:

Photosensitivity	Yes ☐	No ☐	Allergies_____
Skin Cancers	Yes ☐	No ☐	_____
CVS/hepatic/			Medical History_____
renal disease	Yes ☐	No ☐	_____
Cataracts	Yes ☐	No ☐	_____
Epilepsy	Yes ☐	No ☐	Previous Skin surgery _____
			_____
			_____

Precautions

UVB (broadband)	Yes ☐	No ☐	MXT	Yes ☐	No ☐
UVB (TLO1)	Yes ☐	No ☐	Retinoids	Yes ☐	No ☐
PUVA	Yes ☐	No ☐	Cyclosporin	Yes ☐	No ☐
Lived Abroad	Yes ☐	No ☐	Radiotherapy	Yes ☐	No ☐
Sunbed use	Yes ☐	No ☐	Pregnancy(PUVA)	Yes	No

Exclusion Factors

Less than 10 years old	Yes ☐	No ☐	Lupus erythematosus	Yes ☐	No ☐
Genophotodermatoses	Yes ☐	No ☐	Photo-induced epilepsy	Yes ☐	No ☐

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 or 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**_____