|  |
| --- |
| nhs_scot_logo **PHOTOSYS REFERRAL FOR**  **PHOTOTHERAPY / PUVA** |
| Label if available, if not please fill in details below: | **Skin Phototype** | **I** | **II** | **III** | **IV** | **V** | **VI** |
| CHI: | Format of consultation: |
| Surname: | Telephone:  | 🞎 |
| Forenames: | Near Me: | 🞎 |
| Address: | In person: | 🞎 |
| Contact tel number: | Postcode: |
|  |  |
| Referred by: Centre referred to: URGENT referral 🞎  |
| Date of GP referral (if new pt): | Planned holidays/periods away: |
|  |  |  |
| **Concomitant systemic retinoid** 🞎 | **Face shield** 🞎 |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Treatment requested:** | **Narrowband UVB** 🞎 |
|  | **Psoralen & UVA (PUVA)** 🞎Systemic (8-MOP) 🞎Systemic (5-MOP) 🞎Bath PUVA 🞎Localised Topical 🞎 |
|  |  |  |
|  | **Area(s) to be treated:** | Whole body 🞎Photo-exposed sites 🞎Hands & Feet 🞎Hands Only 🞎Feet Only 🞎Legs 🞎Scalp 🞎Entire Male Body 🞎 |

 **PRIMARY DIAGNOSIS: (tick one box only)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **01** | Psoriasis |  | **09** | Vitiligo |  |
| **02** | Palmar Plantar Pustulosis |  | **10** | Mycosis and Pre-mycosis Fungoides |  |
| **03** | Atopic Eczema |  | **12** | Lichen Planus |  |
| **04** | Other Dermatitis |  | **13** | Granuloma Annulare |  |
| **05** | Nodular Prurigo |  | **14** | Pityriasis Lichenoides Chronica |  |
| **06** | Polymorphic Light Eruption |  | **15** | Alopecia Areata |  |
| **07** | Pruritus |  | **16** | Other: …………………………………. |  |
| **08** | Chronic Urticaria |  |  |  |  |

 **Important Additional Diagnosis**………………………………………….
 **GENERAL RISKS: DISEASE EXTENT:draw**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **100** | Pregnancy (for oral PUVA) |  |  |
| **101** | <18 Years of age |  |  |
| **102** | SLE |  |  |
| **103** | Severe renal or hepatic impairment (for PUVA) |  |  |
| **104** | Known severe adverse reaction to psoralens |  |  |
| **105** | Concomitant systemic immunosuppression |  |  |
| **106** | Concomitant topical calcineurin inhibitor |  |  |



**SKIN CANCER RISK FACTORS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **YES** | **NO** |  |  | **YES** | **NO** |
| **200** | Prior PUVA/UVB therapy |  |  | **209** | Sunbed (>50 sessions/yr >2 yrs) |  |  |
| **201** | Lived for >1yr in the tropics |  |  | **212** | Personal history of skin cancer |  |  |
| **202** | Radiotherapy |  |  | **215** | Others |  |  |

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Patient is at increased risk of skin cancer and should be tagged on Photosys for annual skin review.** Please note that such patients are in addition to those patients who have had > 500 cumulative UVB treatments or >200 PUVA treatments who are automatically identified for annual skin review through Photonet. |  |  |

The treatment and possible side effects have been explained to me.

I confirm that I have been given a copy of the Photonet leaflet explaining how my

data might be used.

I confirm I have been offered a patient Information Leaflet about the relevant type of phototherapy.

I agree to undertake a course of Phototherapy.

**Consultant / Clinic: …………………………… Date:… … … … … … .………….**

**Patient’s signature:…………………………… Clinician’s signature:… … … … … …**

|  |
| --- |
| **FOR COMPLETION BY PHOTOTHERAPY UNIT** |

Starting date: \_\_\_\_/\_\_\_\_/\_\_\_\_ MPD = \_\_\_\_\_\_\_\_ MED = \_\_\_\_\_\_\_\_ End date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Appropriate delay in treatment (either at clinician or patient request)

 Reason for delay in treatment (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Dose: PUVA = \_\_\_\_\_\_\_\_J/cm2 UVB = \_\_\_\_\_\_\_\_\_\_ J/cm2 UVA1 = \_\_\_\_\_\_\_\_ J/cm2

No. of treatments: \_\_\_\_\_\_\_\_

**Result:** Cleared 🞎

 Minimal residual activity 🞎

 Moderate clearance 🞎

 Minimal improvement 🞎

 No change 🞎

 Worse 🞎

 Not Applicable 🞎

 Did not complete course (DNA) 🞎

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adverse effects/severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Painful Erythema? (Grade 3 or 4) **YES/NO**

 If Yes: Localised 🞎 Generalised 🞎

**Treatment on discharge:**

Discharge to G.P. 🞎

Review – referring clinic 🞎 in …… months

Open appointment given 🞎

Standard letter 🞎

Advised to use Topical Therapy **YES/NO**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_**