Name

DOB

ID

DR MAGNUS LYNCH

CONSULTANT DERMATOLOGIST & DERMATOLOGICAL SURGEON

Isotretinoin Consent Form

Please tick

ALL PATIENTS

I have been informed of common risks of treatment including dryness of the skin, eyes and lips; nosebleeds; sun-sensitivity; muscle and joint aches; impaired night vision and increased fats in the blood (hyperlipidamia). ☐

I have been informed of rarer risks of treatment including inflammation of the liver (hepatitis) or pancreas (pancreatitis); raised pressure within the brain; sexual side effects (which rarely can persist after stopping treatment) and inflammatory bowel disease. ☐

I understand that this is not a complete list of all possible side effects and that additional side effects that are not widely recognised at the present time may become apparent in the future. ☐

I have been informed that isotretinoin can cause mood disturbance and depression and has rarely been associated with suicide. I will immediately stop taking isotretinoin and contact my doctor if I notice changes in my mood or depression. ☐

I understand that I must not donate blood during treatment with isotretinoin and for at least one month afterwards. ☐

I understand that I will require regular follow up appointments (after one month and then at a minimum every three months) and blood tests (a minimum of one blood prior to treatment and one blood tests whilst taking isotretinoin). I understand that if I take isotretinoin without completing the advised blood tests I am risk of serious or life-threatening side effects. ☐

I have been provided with a patient information leaflet produced by the British Association of Dermatologists on isotretinoin. I understand that this contains critical safety information and I will read this in detail prior to starting treatment. ☐

I am aware that acne may worsen once Isotretinoin has been started. Rarely this can lead to a severe flare of the acne resulting in scarring. ☐

FEMALE ONLY

I understand that isotretinoin can cause serious birth defects and that I must not take isotretinoin if I am pregnant or breast feeding. ☐

I understand that if I am sexually active I must use two methods of contraception for at least one month prior to treatment, for the duration of treatment and for a minumum of one month after completing the course of treatment. ☐

I have been informed that I must tell my doctor immediately and stop taking isotretion if I become pregnant or believe that I may be pregnant. ☐

I have been informed that the Medicines and Healthcare products Regulatory Agency advises that all women with child-bearing potential are enrolled in a pregnancy prevention programme (full details are available in the British Association of Dermatologists patient information leaflet). This includes the requirement to attend the clinic monthly for a pregnancy test. I am aware that should I opt out of the pregnancy prevention programme I am responsible for not becoming pregnant during the course of treatment. ☐

I would like to participate in the pregnancy prevention programme: ☐

OR

I would like to opt out of the pregnancy prevention programme: ☐

Signed (patient)	Print name (patient)	Date

Signed (doctor)

Print name (doctor)