

Name
DOB
ID

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CONSULTANT DERMATOLOGIST & DERMATOLOGICAL SURGEON

## Isotretinoin Consent Form

### 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).

Please tick

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 the 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.

### 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 minimum of one month after completing the course of treatment.

I have been informed that I must tell my doctor immediately and stop taking isotretinoin 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:

.....  
Date

.....  
Signed (patient)

.....  
Print name (patient)

.....  
Signed (doctor)

.....  
Print name (doctor)