

UNIT NO.

NAME

BIRTH DATE:

VISIT NUMBER:

(If handwritten, record name, unit no., birth date, and visit no.)

YALE-NEW HAVEN HOSPITAL

20 York Street New Haven, CT 06510

PHOTOTHERAPY CENTER

DOCTOR'S ORDERS

Phone (203) 688-1199 Fax (203) 688-9290

UVB THERAPY

Date_____ Time_____

DIAGNOSIS:_____

Broad Band Narrow Band

Treatments per week: _____ or Treatments per month: _____

Starting Dose: per skin type millijoule dose_____

Increase 30% initially until minimal erythema dose (MED)

Increase 10% each treatment Increase 20% each treatment Hold at _____ millijoules

Hold for signs of photo toxicity (erythema, burning, blistering, moderate to severe pruritus)

Treat hands Treat feet Shield face Shield groin

Special instructions:_____

Systemic medications:_____

Topical medications:_____

***Follow-up appointment scheduled for:**_____

(Please refer to below timetable)

Doctor's Signature

Please print name

PUVA THERAPY

Date_____ Time_____

DIAGNOSIS:_____

Psoralen dose

Patient's weight:_____

Oxsoalene Ultra dosage_____ mg 1-1/2 hours before treatment

8MOP dosage _____ mg 2 hours before treatment

8MOP soak _____ ml _____ liter x _____ minutes

Treatments per week: _____ or Treatments per month: _____

Starting Dose: per skin type joule dose_____

Increase 0.5 joule/treatment Increase 0.5 joule every other treatment

Increase 1.0 joule /treatment Hold at _____ joules

Hold for signs of photo toxicity (erythema, burning, blistering, moderate to severe pruritus)

Treat hands Treat feet Shield face Shield groin

Special instructions:_____

Systemic medications:_____

Topical medications:_____

***Follow-up appointment scheduled for:**_____

(Please refer to below timetable)

Doctor's Signature

Please print name

*** Mandatory Referring Physician Follow-up Appointment Timetable**

Treatment Frequency	Follow-up
3 x / wk	Every 6 weeks
2 x / wk	Every 8 weeks
1 x / wk	Every 3 months
1 - 2 x / month	Every 6 months
1 x every other month	Every 6 months
1 x every three months	Yearly



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