Stephanie Amey, RDHAP, BS

Photobiomodulation Therapy (PBM) for the prevention of Oral Mucositis (OM)

Acknowledgement of Consent for Laser Treatment

About

Photobiomodulation (PBM) therapy is a non-invasive, drug-free, painless therapy that uses the power of light to stimulate increased blood flow, improve oxygenation, reduce pain and accelerate cell activity. PBM is a very safe and predictable form of treatment. The absorption of red and infrared light produces a photochemical and photobiological interaction within the cell. This process stimulates the production of ATP within the cell and maintains healthy cell function. It has become a key factor in preventing and treating Oral Mucositis (OM) for patients undergoing cancer treatments and is recommended by MASCC. (Multinational Association of Supportive Care in Cancer)

Adverse Effects

- Adverse effects from laser therapy are extremely rare. A reaction may occur in individuals with a diagnosed genetic photosensitivity disorder.
- Extended periods of direct exposure to the light can damage the retina in your eye. The light will never be aimed towards the patient's eyes, however, as a precaution, protective eyewear will always be provided.

Acknowledgement

This authorization and informed consent is given of my own free will after the clinician has explained the risks and benefits of PBM therapy. All questions have been welcomed and answered. I understand the purpose of this treatment is to prevent and/or reduce the severity of oral mucositis in the event that it occurs.
No guarantee of success has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand that the intention of the procedure is to relieve me of pain and suffering or eliminate a potential pathologic condition and the benefits of the proposed treatment far outweigh the alternatives.

Please initial before signing to acknowledge your consent. _____

By signing below you acknowledge that you have read this document, understand the information presented and have had all of your questions answered satisfactorily.
I understand this explanation of PBM therapy. I have had an opportunity to have my questions answered regarding the proposed procedure. I therefore give consent to having the photobiomodulation therapy.

_____ _____ _____

Print Patient's Full Name Patients' Signature or Responsible Party Date