



University of  
Nottingham  
UK | CHINA | MALAYSIA

# Handbook for using NB-UVB Light Devices and topical corticosteroids

---

This handbook is based on the one developed by the Centre of Evidence Based Dermatology and Nottingham Clinical Trials Unit for use by participants in the HI-Light Vitiligo Trial.

References to trial procedures have been removed from the handbook to enable it to be used by local phototherapy teams providing treatment for patients with vitiligo.

It is not designed to enable anyone to undertake any kind of phototherapy treatment independently, without appropriate supervision by suitably qualified medical professionals.

The treatment plan is a suggested plan only. Medical professionals are free to copy, adapt, amend and re-use the handbook in accordance with the advice of their medical teams. It is entirely the responsibility and liability of local phototherapy/dermatology teams to ensure that patients who use the handbook understand its contents fully and can follow the instructions safely.

Neither the Centre of Evidence Based Dermatology nor Nottingham Clinical Trials Unit accept any responsibility or liability for any harm that may arise from the use of this handbook in clinical practice.

*The Centre of Evidence Based Dermatology and Nottingham Clinical Trials Unit are divisions of the University of Nottingham.*

*The HI-Light vitiligo trial was funded by the National Institute for Health Research (NIHR) Health Technology Assessment (HTA) programme (project number 12/67/12). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the Health Technology Assessment programme, NIHR, NHS or the Department of Health.*

# Important information

In case of side effects, treatment queries or medication changes, call your local phototherapy team

Contact details for your local phototherapy team:

Name of team member(s).....

Supervising Consultant.....

Contact telephone number.....

Contact Email address.....

**Treatment for an overdose of UVB light is to apply a strong steroid ointment (such as clobetasol propionate 0.05%) twice a day for 2-3 days. You will need a prescription. If you need to obtain this through an emergency department, please show this manual to a doctor so that they know what to prescribe.**

# How often to use your treatments

## Light therapy

Use every other day (3-4 times a week). DO NOT treat your skin every day.

- For information about missed light therapy treatments, see page: 8
- For information about light therapy side effects, see page: 8

## Ointment

Apply every day, on alternate weeks (one week apply once a day for 7 days, the next week do not apply at all).

If you are applying the ointment on a day that you are also using the light therapy unit, you should apply the ointment no less than two hours after using the unit.

An example of two weeks of treatment:

		DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
WEEK 1	LIGHT	✓	✗	✓	✗	✓	✗	✓
	OINTMENT	✗	✗	✗	✗	✗	✗	✗
WEEK 2	LIGHT	✗	✓	✗	✓	✗	✓	✗
	OINTMENT	✓	✓	✓	✓	✓	✓	✓

You can treat as many patches of your vitiligo as you would like with both the light therapy unit and the ointment.

## Your light treatment schedule

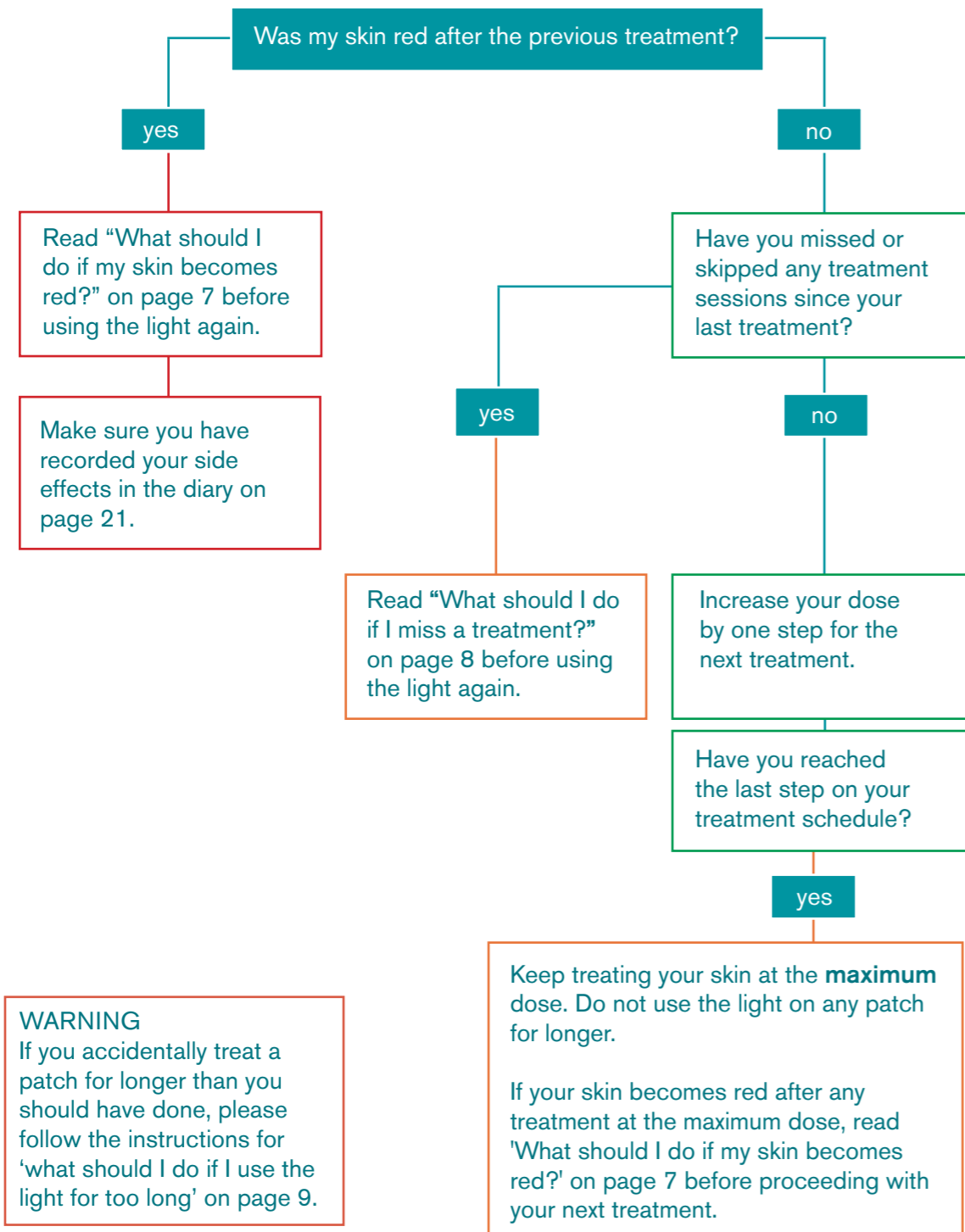
STEP	TREATMENT DURATION (minutes: seconds)	STEP	TREATMENT DURATION (minutes: seconds)	STEP	TREATMENT DURATION (minutes: seconds)
START → 1	00:15	13	01:23	25	04:22
2	00:29	14	01:32	26	04:48
3	00:32	15	01:41	27	05:17
4	00:35	16	01:51	28	05:48
5	00:39	17	02:02	29	06:23
6	00:43	18	02:14	30	07:02
7	00:47	19	02:28	31	07:44
8	00:52	20	02:43	32	08:30
9	00:57	21	02:59	33	09:21
10	01:03	22	03:17	34	10:17
11	01:09	23	03:36	35	11:19
12	01:16	24	03:58	36	12:27
				37	13:42 ← MAX

### Please follow these simple steps to start your treatment:

- 1 Do not use any products on your skin in the 2 hours before you use the light. Cosmetic camouflage can be removed just before treatment.
- 2 Ensure you and anyone helping you is wearing the protective glasses / goggles before switching on the light. A cotton glove should be worn on the hand holding the light unit.
- 3 Make sure the plastic comb is attached to light. Plug the light in, and turn it on, placing it face down on a flat surface. When switched on and not being used for a treatment, always keep the unit face down to protect your eyes and reduce light exposure.
- 4 Allow it to warm up for no less than 2 minutes before starting your treatment.
- 5 Set your digital timer to the required treatment time. Record your treatment time in your treatment diary (pages 12-20).
- 6 Start the light treatment. For small patches of vitiligo you should hold the light over the patch, using the plastic comb to provide a safe distance between the light and your skin. For larger patches of vitiligo, move the light around in a small circular motion over the whole patch. If you find it uncomfortable to hold the light in position for the amount of time needed, you might find it helpful to sit or lie down, or to ask someone for assistance.
- 7 Switch off and unplug your light after treatment. Once cooled, store the unit in a safe place, out of the reach of children.

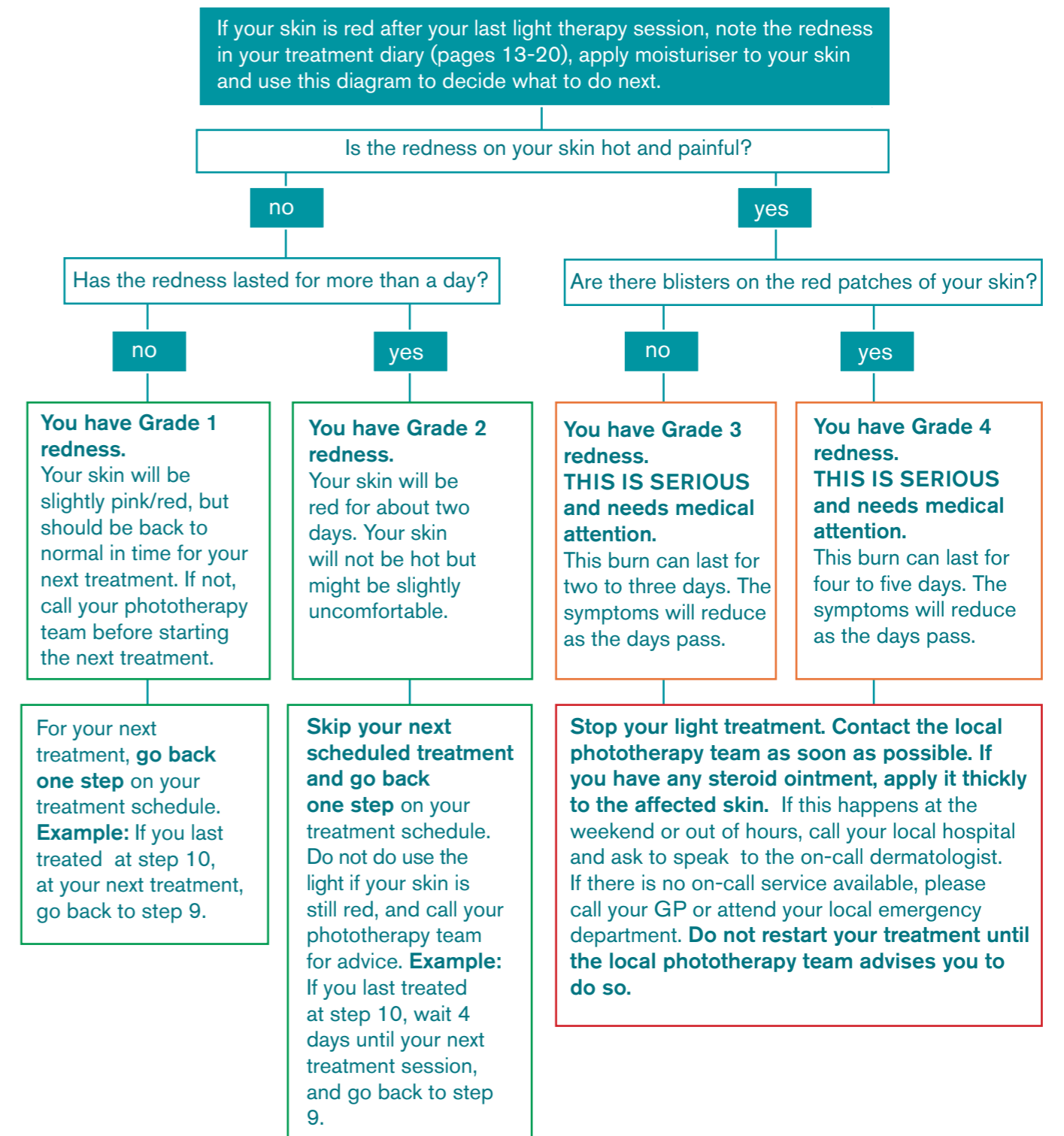
# How to use your light treatment schedule

- START your first dose at Step 1
- You should use your light every other day (unless you have had a side effect, see pages 7-8)
- Before each treatment ask yourself:



# What should I do if my skin becomes red?

Some reddening of the skin after light therapy is normal. It will take between four and 24 hours after your light therapy session for the skin to become red. However, if the skin looks very red, or is painful then you will need to change your treatment schedule a little.



# What should I do if I develop side effects other than redness?

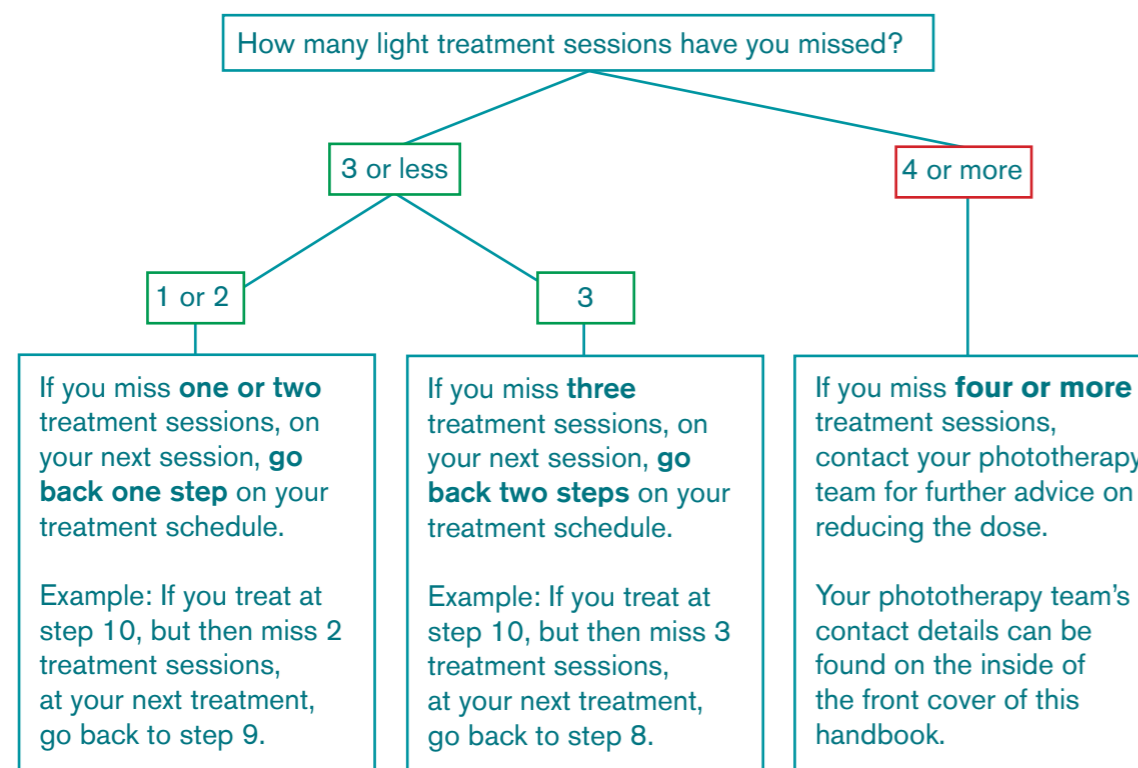
It is extremely important to regularly check your skin to ensure that you are using the treatments safely.

Side effect	What to do
Itchy or dry skin	Apply moisturiser 3-4 times a day. Do NOT apply moisturiser in the 2 hours before light treatment as this can act like a sunscreen and stop the treatment working. You can continue treatment as normal.
Tan around edges	This is normal. You can continue treatment as normal.
Rash	Stop the treatment immediately. Call your phototherapy team. If out of hours and the rash is causing significant symptoms, seek medical assistance.
Cold sore	Stop light treatment until the cold sore has healed. Call your phototherapy team to decide what dose to restart your light treatment at.

- If you have any other questions about side effects, please call your phototherapy team for advice before starting your next treatment
- Each time you experience a new side effect please record it on the log on page 21

## What should I do if I miss a light therapy treatment session?

If for any reason other than side effects, you have missed one or more treatment sessions (e.g. you were busy or away and didn't take your unit with you) please do the following:



# What should I do if I accidentally use the unit for too long?

If you accidentally use the light more than 20% longer than the time you should have that day:

1. Apply a thick layer a thick layer of steroid ointment to the exposed skin and seek medical help.
2. You will need to see a doctor as soon as possible (Call your research nurse. If out of hours: see an emergency GP, on call dermatologist at your local hospital or the emergency department).

Treatment for an overdose of UVB light is to apply a steroid ointment called clobetasol propionate 0.05% twice a day for 2-3 days. You will need to get a prescription for this from a doctor.

3. Contact your phototherapy team as soon as possible to discuss when to restart your light treatment.

## How to safely treat the eyelids or patches close to the eyes

- Someone must always help you with the treatment
- You do not need to wear the glasses/goggles when treating the eyelids, but you must keep your eyes closed at all times
- Your closed eyelids will protect your eyes from the light but DO NOT open your eyes at any point during the light treatment as even very short exposure can be harmful to the eyes

## What if I start new medicines during the trial (prescription or over the counter)?

- If you are prescribed or purchase a new medication, please contact your phototherapy team for advice before continuing light treatment.
- Medication changes: Please inform your phototherapy team of any changes to existing medication during the treatment

## What else could have an effect with light therapy?

- Cosmetics\* and perfumes: On treatment days, avoid using perfumed products and cosmetics on the treated areas as these can make your skin more sensitive to light
- **\*Cosmetic camouflage can be used, and taken off just prior to the light therapy treatment session**
- Moisturisers: You should continue to use moisturisers, but do NOT use any on your vitiligo patches in the two hours before treatment, as this can act like a sunscreen and stop the treatment working
- Sunbeds and sunbathing should be avoided throughout the course of treatment

Whenever you go out into the sun, apply high SPF sun creams (factor 50) This is because you need to limit the amount of other UV light that your skin is receiving whilst using the light therapy.

## What should I do if I have a technical problem with the light unit?

If you need advice regarding mechanical problems with the unit or have any problems with its accessories (glasses / goggles, gloves, timer), please contact your phototherapy team, whose number can be found on the inside of the cover to this handbook.

## When do I apply the ointment?

- Apply the ointment to the vitiligo patches once a day on alternate weeks (i.e. apply it once a day for one week, then do not apply it at all the next week and so on)
- It is best to apply the ointment at night before bedtime
- Do NOT apply the ointment before using the light, as it may act like sunblock
- Apply the ointment at least two hours after using the light therapy unit. If applied too soon, the anti-inflammatory effect of the steroid in the ointment may reduce the effects of the light

## How do I apply the ointment?

As a general rule, to treat a patch of vitiligo the size of your palm, you need to use a pea-sized amount of ointment.

- Depending on the size of the patches of vitiligo, you need to use a slightly different amount of ointment
- It should go on in a thin layer that is enough to make the skin glisten slightly
- It should not go on in a thick layer as it will not get absorbed into the skin

If treating a patch around the eyes, never use the ointment closer than 1 cm to your eyelash line. For a precise application, use the tip of your little finger or a cotton bud.

## When should I stop applying the ointment?

- You should only stop applying the ointment when you have completed your course of treatment as instructed by your local phototherapy team, or if your normal skin colour has completely returned to your vitiligo patch (whichever is sooner).
- **You should also stop applying the ointment if you experience any of the side-effects outlined below**

## What are the possible side effects?

Corticosteroid ointments are generally very safe when used as described in this study – with a break of seven days between periods of treatment to allow the skin to rest.

### Possible side effects that might occur:

- skin thinning (atrophy)
- bruising
- stretch marks (striae)
- spidery blood vessels in the skin (telangiectasia)
- acne-type spots
- excess hair growth (hypertrichosis)

If you think these or any other side effects may be occurring, contact the phototherapy team for advice (you can find the contact details inside the front cover of this handbook).

## Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

### Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 1	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 2	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 3	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 4	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 5	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 6	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		



# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 7	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 8	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 9	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 10	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 11	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 12	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 13	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 14	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		



## Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

### Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 1	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 2	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 3	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 4	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 5	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 6	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 7	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 8	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 9	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 10	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 11	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 12	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 13	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 14	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		





## Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

### Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 1	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 2	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 3	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 4	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 5	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 6	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 7	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 8	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 9	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 10	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 11	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 12	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light				
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects			
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions	
Week 13	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
Week 14	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>		

# Treatment diary

Please record all of your treatments in this diary

- Record any skin redness after light therapy using the table on page 7 to decide what grade it is
- Record other side effects from treatments in the side effects log on page 21

## Remember:

- Light Therapy should be used every other day (3-4 times per week)
- Ointment should be applied every day, on alternate weeks (one week on, one week off)

Date you started this page		Only fill in the section below on the days you use the light			
___ / ___ / ___		Fill in before treatment	Fill in if you experience side effects		
Day	Treatment	Treatment duration	Redness grade	Other new side effect (if yes, fill in log)	Comments/actions
Week 15	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
Week 16	1 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	2 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	3 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	4 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	5 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	6 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	
	7 Light <input type="checkbox"/> Ointment <input type="checkbox"/> None <input type="checkbox"/>	:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> No redness <input type="checkbox"/>	YES <input type="checkbox"/>	