# Treatment Evidence Form
## Unit 849 – Laser and Light Treatments for Hair Removal

**College Name:**
**College Number:**
**Learner Name:**
**Learner Number:**
**Date:**

**Client Name:**
**Address:**

**Profession:**
**Tel. No:** Day
Eve

**PERSONAL DETAILS**
**Age group:** Under 20☐ 20–30☐ 30–40☐ 40–50☐ 50–60☐ 60+☐
**Lifestyle:** Active☐ Sedentary☐
**Last visit to the doctor:**
**GP Address:**
**No. of children (if applicable):**
**Date of last period (if applicable):**

**CONTRAINDICATIONS REQUIRING MEDICAL REFERRAL OR THE CLIENT TO INDEMNIFY THEIR CONDITION IN WRITING PRIOR TO TREATMENT (*select if/where appropriate):***

Any condition already being treated by a GP, dermatologist or another skin therapist ☐
Medical oedema ☐
Osteoporosis ☐
Arthritis ☐
Nervous/Psychotic conditions ☐
Recent operations ☐
Diabetes ☐
Asthma ☐
Bell's Palsy ☐
Trapped/Pinched nerve ☐
Inflamed nerve ☐
Acute rheumatism ☐

**CONTRAINDICATIONS THAT RESTRICT TREATMENT (*select if/where appropriate):***

Fever ☐
Contagious or infectious diseases ☐
Under the influence of drugs or alcohol ☐
Cancer ☐
Pregnancy ☐
Drugs or medications that cause photo-sensitisation or skin thinning effects ☐
Herbal remedies that cause photo-sensitisation ☐
Allergies to the products or materials used ☐
Epilepsy ☐
Cardio-vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Connective tissue disorders (scleroderma) ☐
Herpes ☐
Skin diseases ☐
Undiagnosed lumps and bumps ☐
Cuts ☐
Bruises ☐
Abrasions ☐
Sunburn ☐
Suntanned skin ☐
Artificial tan until the product has faded from the skin ☐
Areas of undiagnosed pain ☐
Skin pigment conditions (vitiligo, melasma moles and pigmented naevi) ☐
Keloid scars ☐
Any metal pins or plates ☐
Loss of skin sensitivity (test with tactile and thermal methods) ☐

**SUN EXPOSURE IN THE LAST 30 DAYS:** YES ☐ NO ☐

**GOALS AND EXPECTATIONS OF THIS TREATMENT:**

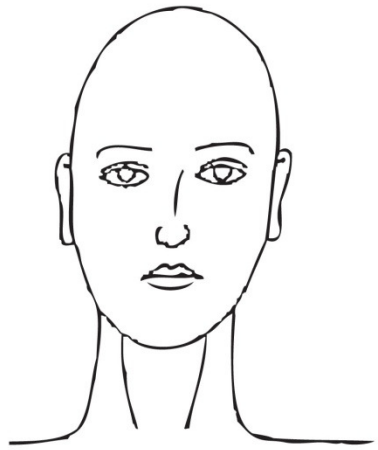
**PATCH TEST:** Date: Area:
**PATCH TEST REACTION:**

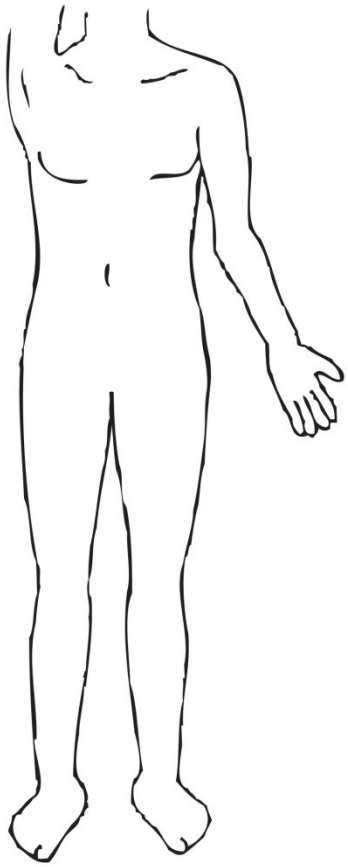
**AREA TO BE TREATED (*select if/where appropriate)*:**
**Face:**

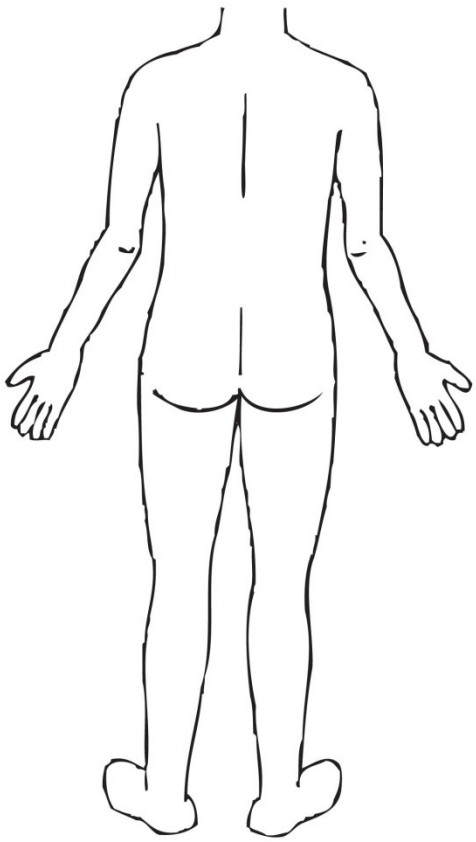
| | | | |
|---|---|---|---|
| Upper lip ☐ | Cheeks ☐ | Side Burns ☐ | Jaw line ☐ |
| Chin ☐ | Neck ☐ | Hairline ☐ | |

**Body:**

| | | |
|---|---|---|
| Underarms ☐ | Upper arms ☐ | Thighs ☐ |
| Bikini line ☐ | Chest ☐ | Lower leg ☐ |
| Forearms ☐ | Back ☐ | Abdomen ☐ |







**PREVIOUS TREATMENT (*select if/where appropriate)*:**
Cosmetic surgery ☐ Micro- pigmentation ☐ Micro-dermabrasion ☐

**Date of previous treatment:**

**Any reaction to previous treatment:** YES ☐ NO ☐
If yes please state reaction:

**SKIN TYPE:**
I ☐ II ☐ III ☐ & Ethnic Skins ☐

**HAIR/SKIN CONDITION**
**DETAILS:**

**Informed Consent:** YES ☐ NO ☐

**Photographic evidence:** YES ☐ NO ☐

**Treatment details (including reaction to treatment and treatment parameters):**

**Client feedback:**

**Aftercare and Home care advice (including treatment interval and treatment monitoring):**

**Learner's Signature……**

**Client's Signature……**

## Sample Disclaimer

### Client Information

Please read carefully and only sign if you are in full agreement with its contents

I ---------- confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant

**Or**

I ---------- confirm that I have understood the treatment and given my medical history, I would prefer to consult with my GP or Consultant prior to receiving the treatment

You should note that if the Learner/Therapist is unable to explain to you the contraindications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant

It is your responsibility and not that of the Learner/Therapist to consult your GP or Consultant

I hereby indemnify the Learner/Therapist against any adverse reaction sustained as a result of the treatment

Client Signature..... Date.....

Learner/Therapist Signature..... Date.....