Treatment Evidence Form

iUBT321 – Apply individual permanent lashes

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

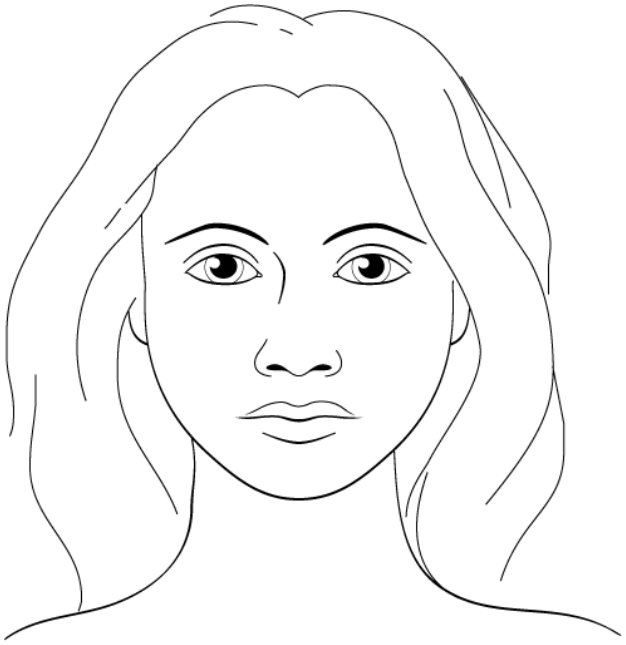
Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP Address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Medical oedema	☐	Diabetes	☐	Undiagnosed pain	☐
Nervous/psychotic conditions	☐	Skin cancer	☐	When taking prescribed medication	☐
Epilepsy	☐	Slipped disc	☐	Whiplash	☐
Recent facial operations affecting the area	☐				

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Scar tissue (2 years for major operation and 6 months for a small scar)	☐	Trapped/pinched nerve affecting the treatment area	☐
Contagious or infectious diseases	☐	Urticaria	☐	Inflamed nerve	☐
Under the influence of recreational drug or alcohol	☐	Recent fractures (minimum 3 months)	☐	Styes	☐
Diarrhoea and vomiting	☐	Sinusitis	☐	Conjunctivitis	☐
Any known allergies	☐	Neuralgia	☐	Watery eyes	☐
Eczema	☐	Sunburn	☐	Eye infection	☐
Undiagnosed lumps and bumps	☐	Migraine/headache	☐	Blepharitis	☐
Localised swelling	☐	Hypersensitive skin	☐	Chemotherapy	☐
Inflammation	☐	Botox/dermal fillers (1 week following treatment)	☐	Trichotillomania	☐
Cuts	☐	Hyperkeratosis	☐	Glaucoma	☐
Bruises	☐	Skin allergies	☐	Contact lenses must be removed prior to treatment	☐
Allergies to adhesives	☐	Cataract	☐	Corneal disease	☐
Diabetic retinopathy	☐	Dry eye syndrome	☐	Eye infection	☐
Infectious and non-infectious skin conditions specific to the eye area (e.g. atopic eczema, atopic dermatitis, psoriasis)	☐	Abrasions	☐		

Sensitivity patch test – (*documentary evidence of patch test to be included):*			
Positive	☐	Negative	☐

Client eye shape and natural eyelash structure			
Eye shape:		Natural eyelash colour:	
Direction of growth:		Natural eyelash length:	
Natural eyelash thickness:		Natural eyelash curvature:	

Previous eyelash treatment details – *(Select if/where appropriate):*		
Previous eyelash treatment details:		
Treatment to include *(select where appropriate):*	Full set of single eyelash extensions ☐	Partial set of single eyelash extensions ☐
		

Treatment details – *(To include products used):*

Client feedback:

Aftercare/home care advice given:

Therapist/learner signature: _____

Client signature: _____

iUBT321 – Skin Sensitivity/Patch Test

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

I _____ confirm that I have received the required patch test(s) 24-48 hours prior to receiving eyelash extension treatment and confirm that I am willing to proceed.

You should note that if the learner is unable to explain to you the treatment contra-actions and contra-indications 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 to consult your GP or Consultant.

I hereby indemnify the learner against any adverse reaction sustained as a result of the treatment

Learner signature: _____ **Date:** _____

Client signature: _____ **Date:** _____

Document History

Version	Issue Date	Changes	Role
v1	09/10/19	First published	Qualifications Administrator