Treatment Evidence Form

iUBT346 – Providing eyelash perming

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

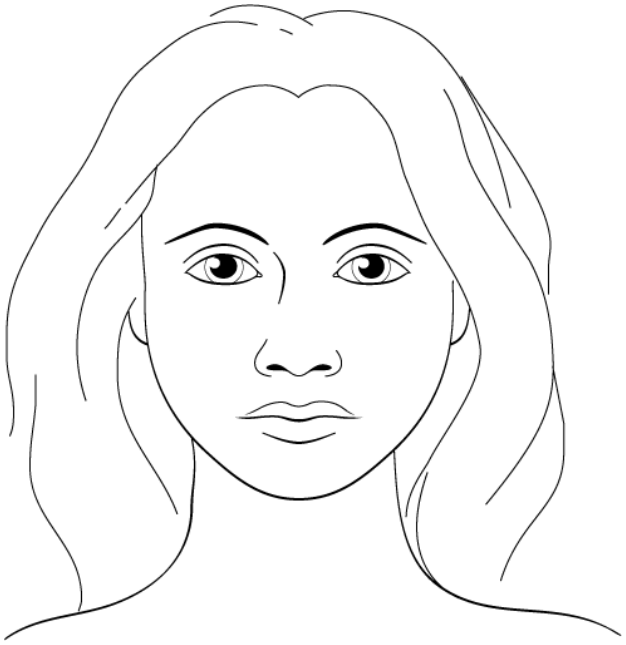
Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

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	☐	When taking prescribed medication	☐
Nervous/psychotic conditions	☐	Skin cancer	☐	Whiplash	☐
Epilepsy	☐	Slipped disc	☐	Undiagnosed pain	☐
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)	☐	Inflamed nerve	☐
Contagious or infectious diseases	☐	Sunburn	☐	Styes	☐
Under the influence of recreational drugs or alcohol	☐	Hormonal implants	☐	Conjunctivitis	☐
Diarrhoea and vomiting	☐	Recent fractures (minimum 3 months)	☐	Watery eyes	☐
Any known allergies	☐	Sinusitis	☐	Eye infection	☐
Eczema	☐	Neuralgia	☐	Blepharitis	☐
Undiagnosed lumps and bumps	☐	Migraine/headache	☐	Chemotherapy	☐
Localised swelling	☐	Hypersensitive skin	☐	Trichotillomania	☐
Inflammation	☐	Botox/dermal fillers (1 week following treatment)	☐	Glaucoma	☐
Cuts	☐	Hyperkeratosis	☐	Contact lenses (must be removed prior to treatment)	☐
Bruises	☐	Skin allergies	☐	Trapped/pinched nerve affecting the treatment area	☐
Eye surgery (approximately 6 months)	☐	Hayfever	☐	Alopecia	☐
Cataract	☐	Corneal disease	☐	Diabetic retinopathy	☐
Dry eye syndrome	☐	Glaucoma	☐	Eye infections	☐
Abrasions	☐	Herpes simplex	☐	Skin conditions specific to the eye and surrounding area (e.g. atopic eczema, atopic dermatitis, psoriasis)	☐

Skin sensitivity patch test *(documentary evidence of patch test to be included):*			
Positive	☐	Negative	☐

Treatment to include (select if/where appropriate):	
Treatment to include *(select where appropriate):*	Eyelash perming ☐ 

Treatment details *(to include products used):*

Client feedback:

Aftercare/home care advice given:

Therapist/learner signature: _____

Client signature: _____

iUBT346 – 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 perming 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	10/10/19	First published	Qualifications Administrator