Treatment evidence form

iUBT378 – Provide facial electrotherapy treatments

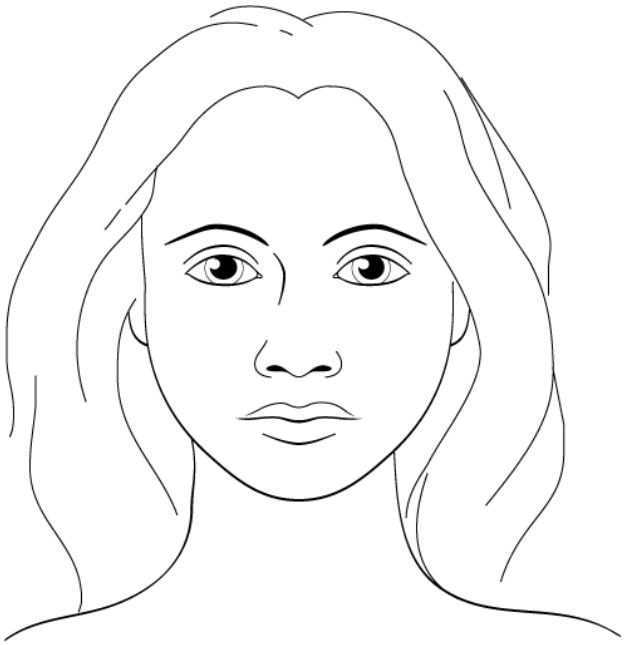
Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

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):*					
Pregnancy	☐	Epilepsy	☐	Inflamed nerve	☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	☐	Recent operations	☐	Conditions causing muscular spasticity (e.g. cerebral palsy)	☐
Haemophilia	☐	Diabetes	☐	Kidney infections	☐
Any condition already being treated by a GP or another practitioner	☐	Asthma	☐	Acute rheumatism	☐
Medical oedema	☐	Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's, Motor neurone disease)	☐	Undiagnosed facial pain	☐
Osteoporosis	☐	Bell's palsy	☐	When taking prescribed medication	☐
Nervous/psychotic conditions	☐	Trapped/pinched nerve	☐	Urinary infections	☐
Medication causing thinning or inflammation of the skin (e.g. steroids, Accutane, retinols)	☐		☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Inflammation	☐	Haematoma	☐
Contagious or infectious diseases	☐	Cuts	☐	Recent fractures (minimum 3 months)	☐
Under the influence of recreational drugs or alcohol	☐	Bruises	☐	Cervical spondylitis	☐
Diarrhoea and vomiting	☐	Abrasions	☐	Any metal pins or plates	☐
Hypersensitive skin	☐	Scar tissues (2 years for major operation and 6 months for a small scar)	☐	Loss of skin sensation (test with tactile test)	☐
Skin diseases	☐	Sunburn	☐	Sinusitis	☐
Undiagnosed lumps and bumps	☐	Hormonal implants	☐	Botox/dermal fillers (1 week following treatment)	☐
Localised swelling	☐	Cancer	☐	Micropigmentation	☐
Anaphylaxis	☐	Muscle fatigue	☐	Pacemaker	☐
Body/Face piercing	☐	Thin skin	☐	After any other heat treatment	☐
Chemical peels	☐	Recent dermabrasion	☐	IPL or laser	☐
Epilation	☐				

Skin test – *(Select if/where appropriate):*				
Moisture content:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Muscle tone:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Elasticity:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Sensitivity:	High ☐	Medium ☐	Low ☐	
Skins healing ability:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Skin tone:	Fair ☐	Medium ☐	Dark ☐	Olive ☐
Circulation:	Good ☐	Normal ☐	Poor ☐	
Pores:	Fine ☐	Dilated ☐	Comodones ☐	Milia ☐
Overall skin type:				
Treatment to include *(select where appropriate):*	Iontophoresis ☐	Direct high frequency ☐	Microcurrent ☐	Faradism ☐
	Desincrustation ☐	Indirect high frequency ☐	Vacuum suction ☐	
				

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

Client feedback:

Aftercare/Home care advice:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	30/10/2019	First published	Qualifications Administrator