Treatment Evidence Form

iUBT349 – Enhance appearance using micro-pigmentation treatment

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

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

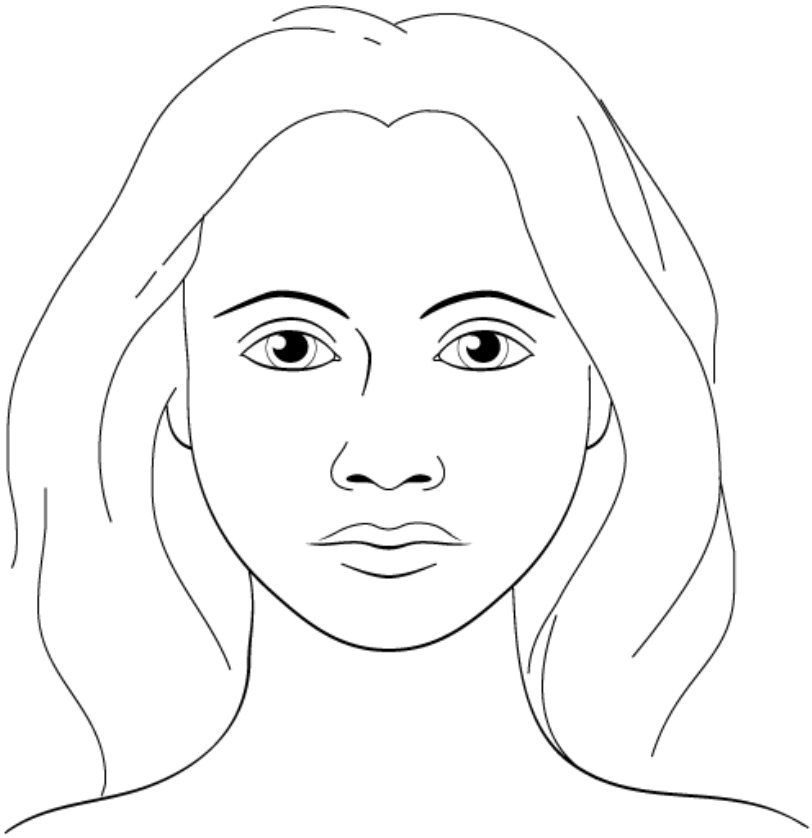
Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP Address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

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):*					
Any condition already being treated by a GP, dermatologist or another skin therapist	☐	Heart disorders	☐	HIV	☐
Pregnancy	☐	Circulatory disorders	☐	Hepatitis	☐
Nervous/psychotic conditions		Pigmented naevi		Herpes simplex	
Recent operations	☐	Chemical peels	☐	Chemotherapy	☐
Diabetes	☐	Recent dermabrasion	☐	Medication causing thinning or inflammation of the skin (steroids, Accutane, retinols)	☐
Inflamed and infectious skin conditions or disorders	☐	Haemophilia	☐	Keloid scars	☐
Contagious diseases	☐	Any condition already being treated by a GP, dermatologist or another skin therapist	☐	Hypertrophic scars	☐
Moles in the treatment area	☐	Blood thinning medication (warfarin)	☐	Alpha hydroxy acids (AHAs)	☐
Diagnosed scleroderma	☐	High blood pressure	☐	Recent dermabrasion	☐
Chemical peels	☐	Diabetes – Type 1	☐		

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Sunburn	☐	Scar tissues (2 years for major operation and 6 months for a small scar)	☐
Drugs or medication that causes photo-sensitisation or skin thinning effects	☐	Suntanned skin	☐	Insulin controlled diabetes	☐
Under the influence of recreational drugs or alcohol	☐	Artificial tan	☐	Haematoma	☐
Diarrhoea and vomiting	☐	Areas of undiagnosed pain	☐	Epilepsy	☐
Allergies to the products or materials used	☐	Loss of skin sensitivity (test with tactile and thermal methods)	☐	Hyper-pigmentation	☐
Cancer	☐	Cuts	☐	Injectables	☐
Skin diseases	☐	Bruises	☐	Facial surgery	☐
Undiagnosed lumps and bumps	☐	Abrasions	☐	Clients under 18 (without appropriate referral or consent)	☐

Contra-indications which prevent treatment – *(Select if/where appropriate):*		
Hyper-pigmentation on the lips ☐	Recent facial surgery (within 6 months) ☐	Allergies ☐
Haemophilia ☐	Hypertrophic scars ☐	Body dysmorphia ☐

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 ☐
Skin condition:				
	Details:			
Hair colour and thickness:				
	Details:			
Hair density and anatomical site:				
	Details:			
Pigmentation/Fitz patrick skin type:	I ☐	II ☐	III ☐	IV ☐
	V ☐	VI ☐		
	Details:			
Artificial tan:	Yes ☐	No ☐		
	Details:			
Skin imperfections:				
	Details:			
Skin temperature:				
	Details:			

Documentary evidence of patch test to be included for pigments:				
Pigments:	Positive ☐	Negative ☐		
Overall skin type/ characteristics (select if/where appropriate):	White ☐	Black ☐	Asian skin type ☐	Mixed ☐
	Dry ☐	Oily ☐	Combination ☐	Mature ☐
	Young ☐	Brief description:		
Area for treatment *(select where appropriate):*	Brows ☐	Eyelids ☐	Lips ☐	
				
Patch test:	Date:		Area:	
Patch test reaction:				
Thermal test:	Date:		Area:	
Thermal test reaction:				
Tactile test:	Date:		Area:	
Tactile test reaction:				

Reason for treatment:

Treatment details *(including details of needle batch numbers and pigments used*):

Photographs:	
Before	**After**

Reaction during treatment:

Client feedback:

After/home care advice given:

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	03/12/2019	First published	Qualifications Administrator