Treatment Evidence Form

iUBT407 – Laser and light treatments for skin rejuvenation

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

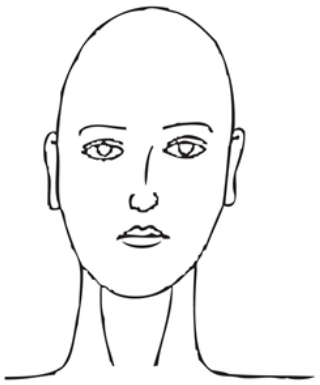
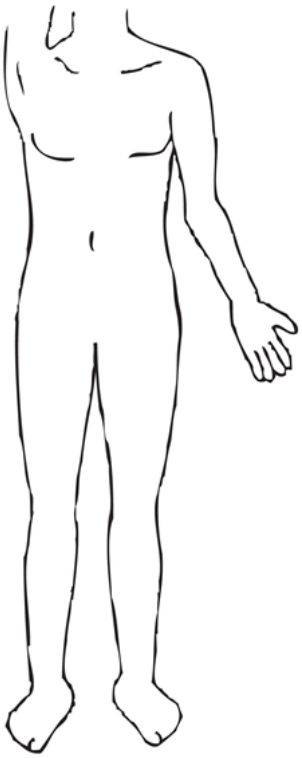
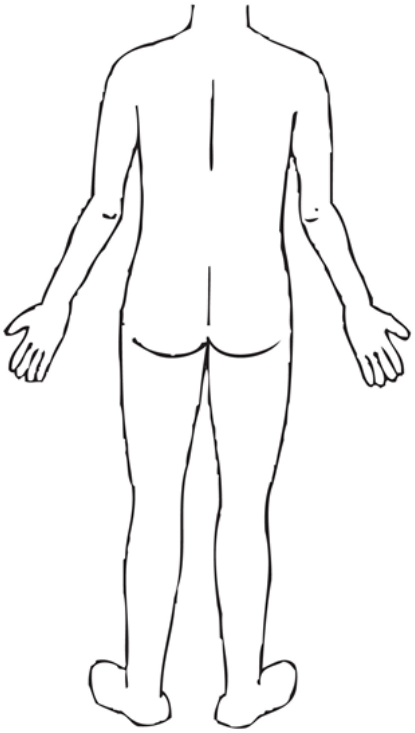
Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

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 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	☐
Undiagnosed skin lesions	☐	Dyschromia in the treatment area	☐	Other:	

Contra-indications 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	☐
Cardiovascular 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	☐
Gold injections	☐	Skin types IV, V & VI	☐	Smoking within two hours of treatment (for diffused redness)	
Loss of skin sensitivity (test with tactile and thermal methods)	☐	Other:			

Treatment					
Treatment:	Skin rejuvenation	☐	Pigmentation	☐	Diffused redness ☐
	Intrinsic ageing	☐	Extrinsic ageing	☐	
Sun exposure in the last 30 days:	Yes	☐	No	☐	

Goals and expectations of this treatment:			
Patch test:	Date:	Area:	
	Parameters used:	Patch test response:	
Area to be treated (face): *(select if/where appropriate)*	Upper lip ☐	Cheeks ☐	Side burns ☐
	Jaw line ☐	Chin ☐	Neck ☐
	Hairline ☐		
	 		
Area to be treated (body): *(select if/where appropriate)*	Back ☐	Shoulders ☐	Underarms ☐
	Upper arms ☐	Forearms ☐	Hands ☐
	Chest ☐	Abdomen ☐	Buttocks ☐
	Thighs/upper leg ☐	Lower leg ☐	
	 		

Previous treatment *(select if/where appropriate)*:	Cosmetic surgery ☐	Micro pigmentation ☐	Microdermabrasion ☐
	Chemical peels ☐	Injectable treatments ☐	
	Other:		
Date of previous treatment:			
Any reaction to previous treatment:	Yes ☐	No ☐	
If yes please state reaction:			
Skin phototypes:	I ☐	II ☐	III ☐
	IV ☐	V ☐	VI ☐
Skin type details:			
Skin condition:	Pigmentation ☐	Skin rejuvenation ☐	
	Area:	Area:	
	Diffused redness ☐	Acne ☐	
	Area:	Area:	
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 signature: _____

Client signature: _____

Sample Disclaimer

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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 contra-indications or is unsure of anything that may supply 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.

Learner signature: _____ **Date:** _____

Client signature: _____**Date:** _____

Document History

Version	Issue Date	Changes	Role
v1	09/01/2020	First published	Qualifications and Regulation Co-ordinator