Treatment Evidence Form

iUBT421 – Provide electrical epilation

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	☐	Recent operations	☐	Conditions causing muscular spasticity	☐
Cardiovascular conditions(thrombosis, phlebitis, hypertension, hypotension, hypotension, heart conditions)	☐	Diabetes	☐	Whiplash and any neck conditions	☐
Cancer	☐	Asthma	☐	Undiagnosed pain	☐
Any condition already being by a GP or another practitioner	☐	Any dysfunction of the nervous system(e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease)	☐	When taking prescribed medication	☐
Medical oedema	☐	Neuralgia	☐	Endocrine disorders	☐
Nervous/psychotic conditions	☐	Inflamed nerve	☐	Slipped disc	☐
Epilepsy	☐				

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Fever	☐	Skin diseases	☐	Sunburn	☐
Contagious or infectious diseases	☐	Hairy moles	☐	Hormonal implants	☐
Under the influence of recreational drugs or alcohol	☐	Undiagnosed lumps and bumps	☐	Abdomen(first few days of menstruation depending on how client feels)	☐
Diarrhoea and/or vomiting	☐	Localised swelling	☐	Haematoma	☐
Mucous membranes	☐	Inflammation	☐	Hernia	☐
Hepatitis B	☐	Varicose veins	☐	Recent fractures (minimum 3 months)	☐
HIV/AIDS	☐	Pregnancy(abdomen)	☐	Cervical spondylitis	☐
Anti-coagulant drugs	☐	Cuts	☐	Metal plates	☐
Bell's palsy	☐	Bruises	☐	Mechanical implants	☐
Loss of skin sensation	☐	Abrasions	☐	Hyper pigmentation	☐
Keloid scarring	☐	Scar tissues(2 years for major operation and 6 months for a small scar)	☐	Botox/dermal fillers(1 week following treatment)	☐
Piercings	☐				

Contra-indications which prevent treatment: *(Select if/where appropriate):*					
Pacemaker	☐	Haemophilia	☐	Cochlear implants	☐

Written permission required by *(either of which should be attached to the consultation form):*			
GP/specialist	☐	Informed consent	☐

Previous treatment:			
Previous epilation treatment	Yes ☐	No ☐	If yes for how long?
Result of previous treatment (if applicable)			
Any skin reaction?			

Present hair and skin condition: – *(Select if/where appropriate):*		
Normal skin/good healing ☐	Sensitive skin/prone to reaction ☐	Oily and blocked ☐
Subject to blemishes/cysts ☐	Prone to pigmentation patches ☐	Very dry skin ☐
Erratic/slow to heal ☐	Dilated capillaries present ☐	Scars present ☐
Strong/pigmented hair ☐	Dense fine hair ☐	
Overall skin/hair type		
Skin/hair condition		
Pigmentation/colour		
Skin texture		
Skin imperfections		
Skin tone		
Skin temperature		
Muscle tone		
Skin elasticity		
UV damage		

Treatment – *(Select if/where appropriate):*				
Area of treatment:	Face ☐	Bikini line ☐	Underarms ☐	Chest/breast ☐
	Upper lip ☐	Chin ☐	Eyebrows ☐	Neck ☐
	Legs ☐	Arms ☐	Abdomen ☐	
Method of treatment:	Short wave diathermy ☐		Blend ☐	
Intensity used:				
Machine used:				
Treatment duration				

Treatment details – *(To include possible reason for hair growth, hair type and reaction to treatment):*

Client feedback:

After/home care feedback:

Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	10/01/2020	First published	Qualifications and Regulator Co-ordinator