

Treatment Evidence Form

iUBT331 – Provide eyelash and eyebrow treatments

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

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

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
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 <input type="checkbox"/>	Diabetes <input type="checkbox"/>	When taking prescribed medication <input type="checkbox"/>
Nervous/psychotic conditions <input type="checkbox"/>	Skin cancer <input type="checkbox"/>	Whiplash <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Slipped disc <input type="checkbox"/>	Undiagnosed pain <input type="checkbox"/>
Recent facial operations affecting the area <input type="checkbox"/>		

Contra-indications that restrict treatment – (Select if/where appropriate):

Fever <input type="checkbox"/>	Bruises <input type="checkbox"/>	Skin allergies <input type="checkbox"/>
Contagious or infectious diseases <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Trapped/pinched nerve affecting the treatment area <input type="checkbox"/>
Under the influence of recreational drugs or alcohol <input type="checkbox"/>	Scar tissue (2 years for major operation and 6 months for a small scar) <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>
Diarrhoea and vomiting <input type="checkbox"/>	Hormonal implants <input type="checkbox"/>	Styes <input type="checkbox"/>
Any known allergies <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>
Eczema <input type="checkbox"/>	Sinusitis <input type="checkbox"/>	Watery eyes <input type="checkbox"/>
Psoriasis <input type="checkbox"/>	Neuralgia <input type="checkbox"/>	Eye infection <input type="checkbox"/>
Dermatitis <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Blepharitis <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Migraine/headache <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>
Localised swelling <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>	Trichotillomania <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Botox/dermal fillers (1 week following treatment) <input type="checkbox"/>	Glaucoma <input type="checkbox"/>
Cuts <input type="checkbox"/>	Hyperkeratosis <input type="checkbox"/>	Contact lenses - must be removed prior to treatment <input type="checkbox"/>
Allergies to tints <input type="checkbox"/>	Any eye surgery (approximately 6 months) <input type="checkbox"/>	Hay fever <input type="checkbox"/>
Infectious and non-infectious skin conditions specific to the eye area: e.g. Atopic eczema, Atopic dermatitis <input type="checkbox"/>		

Client feedback:

Aftercare/home care advice given:

Therapist/learner signature: _____

Client signature: _____

iUBT331 – 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 and/or eyebrow 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	31/10/19	First published	Qualifications Administrator
v2	14/01/2020	Amended consultation to treatment evidence	Qualifications and Regulation Co-ordinator