

# Treatment Evidence Form

iUBT305 – Provide facial skincare

|                        |  |
|------------------------|--|
| <b>Centre name:</b>    |  |
| <b>Centre number:</b>  |  |
| <b>Learner name:</b>   |  |
| <b>Learner number:</b> |  |
| <b>Date:</b>           |  |

|                          |          |  |
|--------------------------|----------|--|
| <b>Client name:</b>      |          |  |
| <b>Address:</b>          |          |  |
| <b>Profession:</b>       |          |  |
| <b>Telephone number:</b> | Day:     |  |
|                          | Evening: |  |

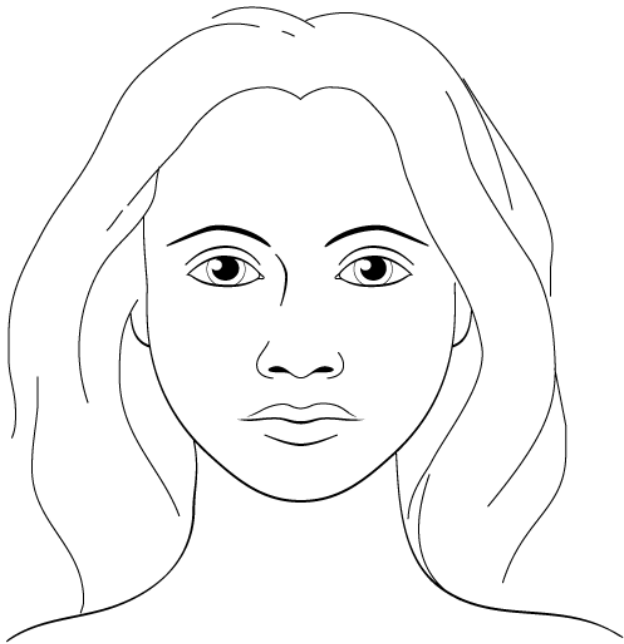
| Personal details:                       |                                   |                                  |                                  |                                    |                                  |                              |
|---|-----------------------------------|----------------------------------|----------------------------------|------------------------------------|----------------------------------|------------------------------|
| 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:<br>(If applicable)  |                                   |                                  |                                  |                                    |                                  |                              |
| Date of last period:<br>(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"/>     | Undiagnosed pain <input type="checkbox"/>                  |
| Nervous/psychotic conditions <input type="checkbox"/>                | Skin cancer <input type="checkbox"/>  | When taking prescribed medication <input type="checkbox"/> |
| Epilepsy <input type="checkbox"/>                                    | Slipped disc <input type="checkbox"/> | Whiplash <input type="checkbox"/>                          |
| Recent facial operations affecting the area <input type="checkbox"/> | Chemotherapy <input type="checkbox"/> |  |

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

|   |   |   |
|---|---|---|
| Fever <input type="checkbox"/>  | Bruises <input type="checkbox"/>  | Botox/dermal fillers (1 week following treatment) <input type="checkbox"/>  |
| Contagious or infectious diseases <input type="checkbox"/>                  | Abrasions <input type="checkbox"/>  | Hyper-keratosis <input type="checkbox"/>                                    |
| Under the influence of recreation drugs of alcohol <input type="checkbox"/> | Scar tissues (2 years for major operation and 6 months for a small scar) <input type="checkbox"/> | Skin allergies <input type="checkbox"/>                                     |
| Diarrhoea and vomiting <input type="checkbox"/>                             | Sunburn <input type="checkbox"/>  | Styes <input type="checkbox"/>  |
| Any known allergies <input type="checkbox"/>                                | Hormonal implants <input type="checkbox"/>  | Watery eyes <input type="checkbox"/>  |
| Eczema <input type="checkbox"/>   | Recent fractures (minimum 3 months) <input type="checkbox"/>                                      | Trapped/pinched nerve affecting the treatment area <input type="checkbox"/> |
| Undiagnosed lumps or bumps <input type="checkbox"/>                         | Sinusitis <input type="checkbox"/>  | Inflamed nerve <input type="checkbox"/>                                     |
| Localised swelling <input type="checkbox"/>                                 | Neuralgia <input type="checkbox"/>  | Eye infection <input type="checkbox"/>                                      |
| Inflammation <input type="checkbox"/>                                       | Migraine/headache <input type="checkbox"/>  | Conjunctivitis <input type="checkbox"/>                                     |
| Cuts <input type="checkbox"/>   | Hypersensitive skin <input type="checkbox"/>  | Blepharitis <input type="checkbox"/>  |

| Skin test – (Select if/where appropriate):       |  |                                       |  |                                  |
|--|--|---------------------------------------|--|----------------------------------|
| Moisture content:                                | Excellent <input type="checkbox"/>   | Good <input type="checkbox"/>         | Fair <input type="checkbox"/>          | Poor <input type="checkbox"/>    |
| Muscle tone:                                     | Excellent <input type="checkbox"/>   | Good <input type="checkbox"/>         | Fair <input type="checkbox"/>          | Poor <input type="checkbox"/>    |
| Elasticity:                                      | Excellent <input type="checkbox"/>   | Good <input type="checkbox"/>         | Fair <input type="checkbox"/>          | Poor <input type="checkbox"/>    |
| Sensitivity:                                     | High <input type="checkbox"/>  | Medium <input type="checkbox"/>       | Low <input type="checkbox"/>           |                                  |
| Skins healing ability:                           | Excellent <input type="checkbox"/>   | Good <input type="checkbox"/>         | Fair <input type="checkbox"/>          | Poor <input type="checkbox"/>    |
| Skin tone:                                       | Fair <input type="checkbox"/>  | Medium <input type="checkbox"/>       | Dark <input type="checkbox"/>          | Olive <input type="checkbox"/>   |
| Circulation:                                     | Good <input type="checkbox"/>  | Normal <input type="checkbox"/>       | Poor <input type="checkbox"/>          |                                  |
| Pores:   | Fine <input type="checkbox"/>  | Dilated <input type="checkbox"/>      | Comedones <input type="checkbox"/>     | Milia <input type="checkbox"/>   |
| Overall skin type:                               |  |                                       |  |                                  |
| Treatment to include (select where appropriate): | Superficial Cleanse <input type="checkbox"/>   | Deep Cleanse <input type="checkbox"/> | Skin analysis <input type="checkbox"/> | Massage <input type="checkbox"/> |
|  | Mask <input type="checkbox"/>  |                                       |  |                                  |
|  |  |                                       |  |                                  |

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

**Client feedback:**

**Aftercare/home care advice given:**

**Therapist/learner signature:** \_\_\_\_\_

**Client signature:** \_\_\_\_\_

## Document History

| Version | Issue Date | Changes                                    | Role                                       |
|---------|------------|--|--|
| v1      | 27/09/2019 | First published                            | Qualifications and Regulation Co-ordinator |
| v2      | 14/01/2019 | Amended consultation to treatment evidence | Qualifications and Regulation Co-ordinator |
|         |            |  |  |