

Treatment Evidence Form

iUBT427 – Skincare and eye 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):

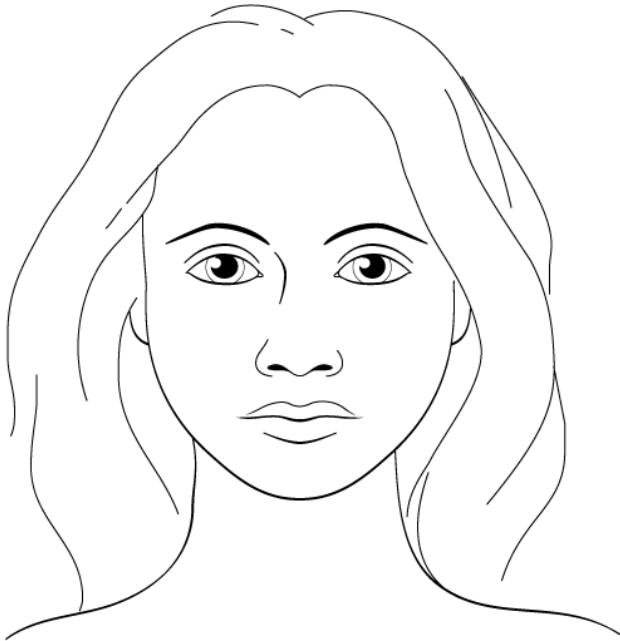
Medical oedema <input type="checkbox"/>	Diabetes <input type="checkbox"/>	When taking prescribed medication <input type="checkbox"/>
Nervous/psychotic conditions <input type="checkbox"/>	Skin cancer <input type="checkbox"/>	Whiplash <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Slipped disc <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"/>	Sunburn <input type="checkbox"/>
Contagious or infectious diseases <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Migraine/headache <input type="checkbox"/>
Under the influence of recreational drugs or alcohol <input type="checkbox"/>	Scar tissues (2 years for major operation and 6 months for a small scar) <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>
Diarrhoea and vomiting <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Botox/dermal fillers (1 week following treatment) <input type="checkbox"/>
Any known allergies <input type="checkbox"/>	Conjunctivitis <input type="checkbox"/>	Hyper-keratosis <input type="checkbox"/>
Eczema <input type="checkbox"/>	Hormonal implants <input type="checkbox"/>	Skin allergies <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>	Styes <input type="checkbox"/>
Localised swelling <input type="checkbox"/>	Sinusitis <input type="checkbox"/>	Watery eyes <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Bruises <input type="checkbox"/>	Trapped/pinched nerve affecting the treatment area <input type="checkbox"/>
Cuts <input type="checkbox"/>	Neuralgia <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>
Eye infection <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"/>	Skin analysis	<input type="checkbox"/>	Eyebrow tweezing	<input type="checkbox"/>
	Deep cleanse	<input type="checkbox"/>	Lash tinting	<input type="checkbox"/>	Massage	<input type="checkbox"/>
	Pre-heat treatment	<input type="checkbox"/>	Brow tinting	<input type="checkbox"/>	Mask	<input type="checkbox"/>
						

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

Client feedback:

Aftercare feedback:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	30/09/2019	First published	Qualifications and Regulation Co-ordinator
v2	14/01/2020	Changed consultation to treatment evidence	Qualifications and Regulation Co-ordinator