

Treatment Evidence Form

iUBT431 – Facial electrical treatments

| | |
|-----------------|--|
| Centre name: | |
| Centre number: | |
| Learner name: | |
| Learner number: | |
| Date: | |

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

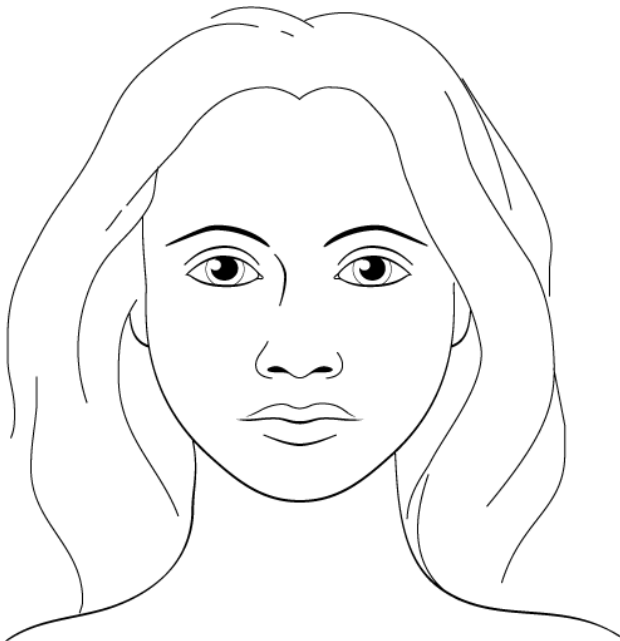
| Personal details: | | | | | | |
|---|-----------------------------------|----------------------------------|----------------------------------|------------------------------------|----------------------------------|------------------------------|
| Age group: | Under 20 <input type="checkbox"/> | 20 – 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):

| | | |
|--|---|--|
| Pregnancy <input type="checkbox"/> | Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) <input type="checkbox"/> | Haemophilia <input type="checkbox"/> |
| Any condition already being treated by a GP or another practitioner <input type="checkbox"/> | Medical oedema <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> |
| Nervous/psychotic conditions <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Recent operations <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Asthma <input type="checkbox"/> | Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) <input type="checkbox"/> |
| Bell's palsy <input type="checkbox"/> | Trapped/pinched nerve <input type="checkbox"/> | Inflamed nerve <input type="checkbox"/> |
| Spastic conditions <input type="checkbox"/> | Kidney infections <input type="checkbox"/> | Acute rheumatism <input type="checkbox"/> |
| Undiagnosed facial pain <input type="checkbox"/> | When taking prescribed medication <input type="checkbox"/> | |

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

| | | |
|---|--|---|
| Fever <input type="checkbox"/> | Contagious or infectious diseases <input type="checkbox"/> | Under the influence of recreational drugs or alcohol <input type="checkbox"/> |
| Diarrhoea and vomiting <input type="checkbox"/> | Hypersensitive skin <input type="checkbox"/> | Skin diseases <input type="checkbox"/> |
| Undiagnosed lumps and bumps <input type="checkbox"/> | Localised swelling <input type="checkbox"/> | Inflammation <input type="checkbox"/> |
| Cuts <input type="checkbox"/> | Bruises <input type="checkbox"/> | Abrasions <input type="checkbox"/> |
| Scar tissues (2 years for major operation and 6 months for a small scar) <input type="checkbox"/> | Sunburn <input type="checkbox"/> | Hormonal implants <input type="checkbox"/> |
| Haematoma <input type="checkbox"/> | Recent fractures (minimum 3 months) <input type="checkbox"/> | Cervical spondylitis <input type="checkbox"/> |
| Any metal pins or plates <input type="checkbox"/> | Loss of skin sensation (test with tactile test) <input type="checkbox"/> | Sinusitis <input type="checkbox"/> |
| Botox/dermal fillers (1 week following treatment) <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"/> | Comodones | <input type="checkbox"/> | Milia | <input type="checkbox"/> | |
| Overall skin type: | | | | | | | | | |
| Treatment to include (select where appropriate): | Iontophoresis | <input type="checkbox"/> | Desincrustation | <input type="checkbox"/> | Direct high frequency | <input type="checkbox"/> | Indirect high frequency | <input type="checkbox"/> | |
| | Microcurrent | <input type="checkbox"/> | Vacuum suction | <input type="checkbox"/> | Faradism | <input type="checkbox"/> | | | |
| |  | | | | | | | | |

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

Client feedback:

After/home care advice:

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 | Amended consultation to treatment evidence | Qualifications and Regulation Co-ordinator |
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