

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: <i>(If applicable)</i>						
Date of last period: <i>(If applicable)</i>						

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):

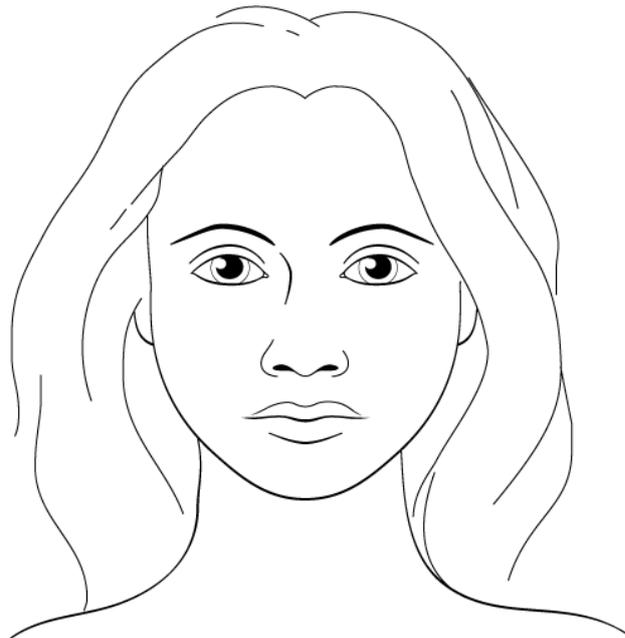
Fever <input type="checkbox"/>	Contagious or infectious diseases <input type="checkbox"/>	Under the influence of recreational drugs or alcohol <input type="checkbox"/>
Diarrhoea and vomiting <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>	Skin diseases <input type="checkbox"/>
Undiagnosed 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