

Treatment Evidence Form

iUBT422 – Provide and maintain gel nail enhancements

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):

Haemophilia <input type="checkbox"/>	Nervous/Psychotic conditions <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>
Any condition already being treated by a GP, dermatologist or another practitioner <input type="checkbox"/>	Recent operations of the hands or feet <input type="checkbox"/>	Undiagnosed pain <input type="checkbox"/>
Medical oedema <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Acute rheumatism <input type="checkbox"/>
Arthritis <input type="checkbox"/>		

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

Fever <input type="checkbox"/>	Bruises <input type="checkbox"/>	Nail separation <input type="checkbox"/>
Infectious or contagious diseases <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Eczema <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"/>	Psoriasis <input type="checkbox"/>
Diarrhoea and vomiting <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>	Loss of skin sensation <input type="checkbox"/>
Any known allergies <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Chilblains <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Repetitive Strain Injury <input type="checkbox"/>	Corns <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Carpal Tunnel Syndrome <input type="checkbox"/>	Verrucae <input type="checkbox"/>
Cuts <input type="checkbox"/>	Severely bitten or damaged nails <input type="checkbox"/>	Wart(s) <input type="checkbox"/>

Diseases and disorder – (Select if/where appropriate):

Beau's line <input type="checkbox"/>	Mould <input type="checkbox"/>	Onychorrhexis <input type="checkbox"/>
Blue nail <input type="checkbox"/>	Onychatrophia <input type="checkbox"/>	Paronychia (Whitlow) <input type="checkbox"/>
Bruised nail(s) <input type="checkbox"/>	Onychauxis <input type="checkbox"/>	Pitting <input type="checkbox"/>
Dermatitis <input type="checkbox"/>	Onychia <input type="checkbox"/>	Psoriasis <input type="checkbox"/>
Discoloured nails <input type="checkbox"/>	Onychocryptosis <input type="checkbox"/>	Pterygium <input type="checkbox"/>
Eczema <input type="checkbox"/>	Onychogryphosis <input type="checkbox"/>	Sepsis <input type="checkbox"/>
Flaking <input type="checkbox"/>	Onycholysis <input type="checkbox"/>	Severely bitten/picked skin around the nail <input type="checkbox"/>
Hang nail(s) <input type="checkbox"/>	Onychomycosis (Tinea Ungium) <input type="checkbox"/>	Transverse ridges <input type="checkbox"/>
Koilonychia <input type="checkbox"/>	Onychophagy <input type="checkbox"/>	Vertical ridges <input type="checkbox"/>
Lamella dystrophy <input type="checkbox"/>	Onychophyma <input type="checkbox"/>	
Leuconychia <input type="checkbox"/>	Onychoptosis <input type="checkbox"/>	

Nail test – (Select if/where appropriate):				
Moisture content:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Cuticle condition:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Skin condition:	Dehydrated <input type="checkbox"/>	Dry <input type="checkbox"/>	Normal <input type="checkbox"/>	
Skin's healing ability:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
Circulation:	Good <input type="checkbox"/>	Normal <input type="checkbox"/>	Poor <input type="checkbox"/>	
Overall nail/skin condition:				

Area to be treated:	
Toenails <input type="checkbox"/>	Fingernails <input type="checkbox"/>

Treatment – (Select if/where appropriate):		
Natural nail overlays <input type="checkbox"/>	Natural tips and overlays <input type="checkbox"/>	Full set <input type="checkbox"/>
Infill <input type="checkbox"/>	Rebalance <input type="checkbox"/>	Removal <input type="checkbox"/>
Nail system used:		
Liquid and powder <input type="checkbox"/>	UV gel <input type="checkbox"/>	Wrap <input type="checkbox"/>

Treatment details – (Must include before and after photographs of treatment):

Client feedback:

After/home care advice given:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	15/01/2019	First Published	Qualification Administrator