

Case Study Consultation Form

UBT454 – Provide superficial chemical skin peeling 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"/>
Occupation:						
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Details of activity:						
GP Address:						

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

Photosensitive medication <input type="checkbox"/>	Supplements and herbal remedies <input type="checkbox"/>	Active inflammatory dermatoses (such as Psoriasis) <input type="checkbox"/>
Allergy to aspirin (salicylic acid) <input type="checkbox"/>	Active bacterial infection <input type="checkbox"/>	Active viral infection <input type="checkbox"/>
Active fungal infection <input type="checkbox"/>	Active herpetic infection <input type="checkbox"/>	Allergy to skin peel ingredients <input type="checkbox"/>
Recent direct sun/UV exposure in the area to be treated <input type="checkbox"/>	Atopic dermatitis <input type="checkbox"/>	Solar keratosis <input type="checkbox"/>
History of skin cancer <input type="checkbox"/>	Vascular diseases <input type="checkbox"/>	Bleeding or clotting disorders <input type="checkbox"/>
Pigmentary disturbance <input type="checkbox"/>	Body dysmorphia <input type="checkbox"/>	Excessive deep skin folds <input type="checkbox"/>
Topical steroid medication <input type="checkbox"/>	Trying to conceive <input type="checkbox"/>	Fake tan applied in the last 14 days in area to be treated <input type="checkbox"/>
Directly over moles <input type="checkbox"/>	Birthmarks <input type="checkbox"/>	Permanent or semi-permanent make-up <input type="checkbox"/>
Impaired healing <input type="checkbox"/>	Immunosuppression <input type="checkbox"/>	Pregnancy <input type="checkbox"/>
Lactation/breast feeding <input type="checkbox"/>	Open wounds <input type="checkbox"/>	Recent radiation treatment <input type="checkbox"/>
Use of isotretinoin (Accutane) <input type="checkbox"/>	Retinoic acid/Retin A products <input type="checkbox"/>	Abrasions <input type="checkbox"/>
Bruises <input type="checkbox"/>	Acne <input type="checkbox"/>	Cuts <input type="checkbox"/>
Allergies <input type="checkbox"/>	Areas of undiagnosed pain <input type="checkbox"/>	Herpes simplex/zoster <input type="checkbox"/>
Botulinum toxin/neuromodulator injections <input type="checkbox"/>	Cardiovascular conditions <input type="checkbox"/>	Anticoagulant medication <input type="checkbox"/>
Contagious or infectious diseases <input type="checkbox"/>	Drugs which cause skin thinning <input type="checkbox"/>	Depression/anxiety <input type="checkbox"/>
Eczema <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Fever <input type="checkbox"/>
Injectable fillers <input type="checkbox"/>	Loss of skin sensitivity <input type="checkbox"/>	Skin diseases <input type="checkbox"/>
Poor mental and emotional state <input type="checkbox"/>	Prior to surgery <input type="checkbox"/>	Recent skin peels or microdermabrasion <input type="checkbox"/>
Epilation <input type="checkbox"/>	Hypersensitive skin keloids <input type="checkbox"/>	Hypertrophic scarring <input type="checkbox"/>

Comments:

Contra-indications that require medical referral – (Select if/where appropriate):

Active acne <input type="checkbox"/>	Radiation treatment <input type="checkbox"/>	Any condition already being treated by a GP or dermatologist <input type="checkbox"/>
Asthma <input type="checkbox"/>	Certain medications including anti-coagulants <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Cardiac disease <input type="checkbox"/>	Renal disease <input type="checkbox"/>	Hepatic disease <input type="checkbox"/>
Renal disease <input type="checkbox"/>	Recent surgery <input type="checkbox"/>	Undiagnosed swelling in treatment area <input type="checkbox"/>
Nervous/psychotic conditions <input type="checkbox"/>		

Comments:

Details of consultation with other aesthetic/medical professionals if relevant

Please specify:

Written permission required by:

Either of which should be attached to the treatment form

GP/Specialist <input type="checkbox"/>	Informed consent <input type="checkbox"/>
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Personal information – (Select if/where appropriate):

Have you had any health problems in the past or present?

If yes, please specify:

Yes ☐ No ☐

Have you been or are you currently under the care of a medical practitioner or other healthcare specialist?

If yes, please specify:

Yes ☐ No ☐

Are you currently taking/using any prescribed or non-prescribed medications (oral or topical)?

If yes, please specify:

Yes ☐

No ☐

Are you currently taking/using any vitamin/mineral supplements or herbal remedies (oral or topical)?

If yes, please specify:

Yes ☐

No ☐

Do you suffer from anxiety, stress, depression and/or are clinically diagnosed?

If yes, please specify:

Yes ☐

No ☐

What are your stress levels?
1 to 10 (10 being the highest)

At work:

At home:

Do you smoke or vape?

If yes, how many per day?

Yes ☐

No ☐

Do you drink alcohol?

If yes, how many units per week?

Yes ☐

No ☐

Are you trying to conceive, pregnant or lactating?

If yes, please specify:

Yes ☐

No ☐

Are you:

Due or having your menstrual period ☐

Method of contraception ☐

Peri-menopausal ☐

Menopausal ☐

Post menopause ☐

Additional details including date of last menstrual period, hormone replacement therapy (HRT) medication or any hormone treatment if relevant:

Do you have any allergies?		
<i>If yes, please provide details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you or have you ever suffered from anaphylaxis?		
<i>If yes, please provide details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How long since your last exposure to sun, sunbed or artificial tan?		
<i>Please specify details:</i>		
Are you currently sun/wind burnt, or do you have an active/artificial tan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wear a sun protectant?		
<i>If yes, please specify SPF/frequency of application:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from Herpes simplex?		
<i>If yes, please specify where outbreaks occur/frequency and likely triggers:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If yes, please specify if/which prophylactic anti-viral is being taken or recommended:</i>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

Have you had any of the following?					
Botox/neuromodulation/anti-wrinkle injections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Injectable dermal fillers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Light based therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depilatory treatments	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Laser/IPL	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Electrolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Microdermabrasion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Facial surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin needling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Exfoliation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin peeling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dermaplaning	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Intralipolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cryolipolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cavitation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Body surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery in the area	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other treatment not listed		

If yes, please specify treatment details (to include treatment dates, frequency, results and client satisfaction with outcome):

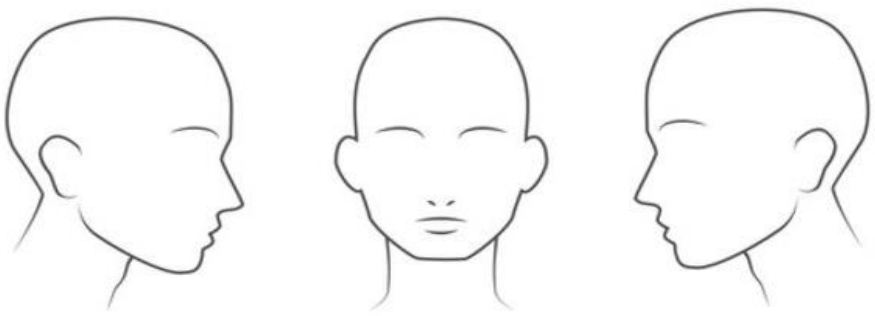
Do you use Retin A or any other prescription skin medication or skincare products?		
<i>If yes, please specify details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

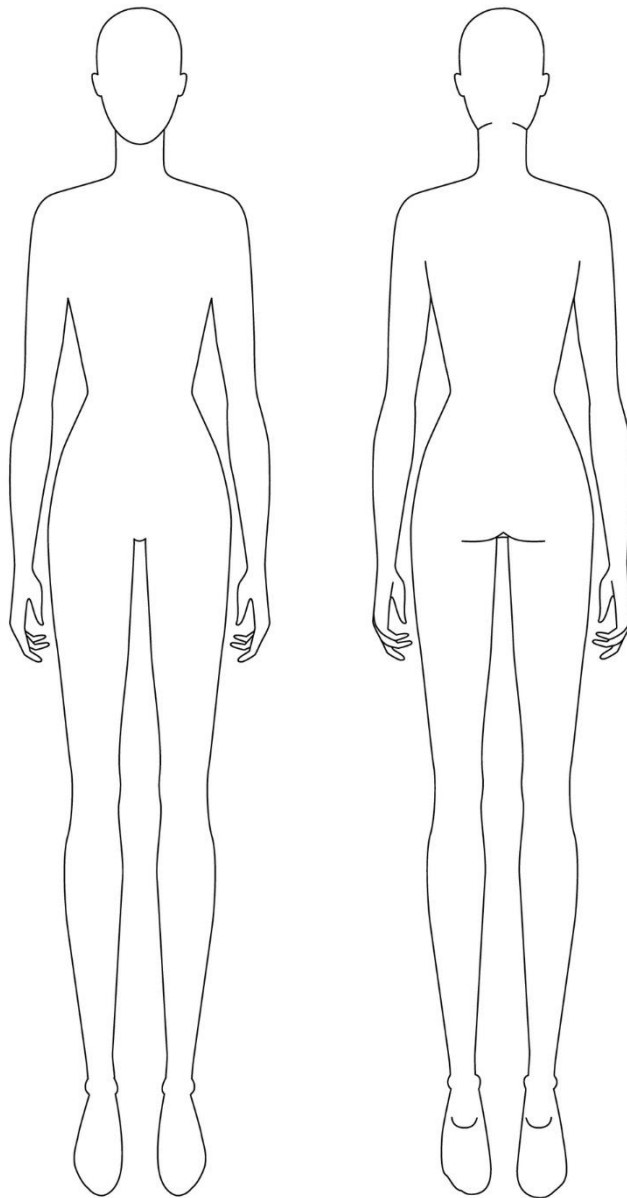
Have you taken/used Isotretinoin or any other skin medication within the last 6-12 months?		
<i>If yes, please specify details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you use or have you ever used home care products containing any of the following?			
Exfoliating granules	<input type="checkbox"/>	Glycolic Acid	<input type="checkbox"/>
Other Alpha Hydroxy Acids	<input type="checkbox"/>	Vitamin A derivatives (Retinol)	<input type="checkbox"/>
		Lactic Acid	<input type="checkbox"/>
		Salicylic Acid	<input type="checkbox"/>
If yes, please specify frequency, skin reaction after use and when last used:			
What is your current daily skin/body care regime, including product details?			
Morning:			
Evening:			
What other aesthetic skin/body treatments/products have been used to prepare the area for treatment?			
Please specify product(s) and active ingredients:			
Details of any planned cosmetic/aesthetic procedures that may impact on the treatment			
Please specify:			
What specific skin/face/body concerns do you have?			
What are your expectations of this treatment?			

Skin/body assessment:			
Skin type and classification	Oily <input type="checkbox"/>	Dry <input type="checkbox"/>	Normal (balanced) <input type="checkbox"/>
	Combination <input type="checkbox"/>	Excessively oily <input type="checkbox"/>	Fitzpatrick scale I <input type="checkbox"/>
	Fitzpatrick scale II <input type="checkbox"/>	Fitzpatrick scale III <input type="checkbox"/>	Fitzpatrick scale IV <input type="checkbox"/>
	Fitzpatrick scale V <input type="checkbox"/>	Fitzpatrick scale VI <input type="checkbox"/>	Other <input type="checkbox"/>
Skin/body characteristics/conditions	Glogau photo damage <input type="checkbox"/>	Hyper pigmentation <input type="checkbox"/>	Hypo pigmentation <input type="checkbox"/>
	Uneven pigmentation <input type="checkbox"/>	Static wrinkles <input type="checkbox"/>	Dynamic wrinkles <input type="checkbox"/>
	Open pores <input type="checkbox"/>	Sensitive <input type="checkbox"/>	Scarring <input type="checkbox"/>
	Vascular lesions <input type="checkbox"/>	Irregularities <input type="checkbox"/>	Itching/Pruritus <input type="checkbox"/>
	Stretchmarks <input type="checkbox"/>	Skin laxity <input type="checkbox"/>	Papules/pustules <input type="checkbox"/>
	Psoriasis <input type="checkbox"/>	Scleroderma <input type="checkbox"/>	Graft versus host disease <input type="checkbox"/>
	Leishmaniasis <input type="checkbox"/>	Temporal arteritis <input type="checkbox"/>	Trauma <input type="checkbox"/>
	Seborrheic dermatitis <input type="checkbox"/>	Hereditary factors <input type="checkbox"/>	Mature <input type="checkbox"/>
	Acne prone <input type="checkbox"/>	Milia <input type="checkbox"/>	Dehydrated <input type="checkbox"/>
	Congested <input type="checkbox"/>	Comedones <input type="checkbox"/>	Other <input type="checkbox"/>

Assessment summary:	
Epidermal thickness	
Intrinsic and extrinsic ageing factors	
Healing capacity	
Surface hydration levels	
Skin texture (pore size)	
Irregularities	
Skin laxity	
Pigmentation	
Photo/sun damage	
Vascular lesions	
Primary and secondary lesions	
Static and dynamic wrinkles	
Additional comments	

Skin sensitivity tests	Date:			
	Area(s) tested:			
	Thermal test:	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Tactile test:	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Product test:	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Additional comments:			
Treatment objectives:	Reduction of fine lines <input type="checkbox"/>	Skin rejuvenation <input type="checkbox"/>	Improvement of stretch marks <input type="checkbox"/>	
	Improvement of pigmentation variations <input type="checkbox"/>	Improved skin texture <input type="checkbox"/>	Improvement of superficial blemishes <input type="checkbox"/>	
	Improvement of skin hydration <input type="checkbox"/>	Improved skin laxity <input type="checkbox"/>	Other <input type="checkbox"/>	
Proposed treatment plan – (detail where appropriate)				



Pre-treatment
photograph
taken:

Yes

☐

No

☐

Comments:

Treatment details:		
Details of skin preparation including protection of vulnerable areas		
Rationale for peel product selected and method of application		
Processing time and modifications where required		
Observed skin reaction and clinical endpoints		
Client tolerance and response to treatment including any cooling methods used		
Neutralising (where necessary) and details of removal process		
Post treatment products in line with manufacturer guidance		
Post-treatment photograph taken:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<p>Client feedback:</p>	
<p>Post-care/home care advice given:</p>	
<p>Recommendations for follow up/maintenance treatments</p>	
<p>Comments:</p>	

Pre-treatment consent and Treatment information

The superficial chemical skin peeling treatment is a non-surgical treatment that uses superficial chemical skin peeling products and procedures to rejuvenate and improve skin condition and appearance. During the treatment you may experience some mild to moderate discomfort such as a sensation of tingling or heat. You should tell your advanced aesthetic practitioner about the sensations you experience during treatment.

Immediately following treatment your skin/body may feel tight or tender/sore. You may also experience mild erythema (redness) and swelling to the area. Some clients may experience mild to moderate flaking of the skin and your advanced aesthetic practitioner will advise on the appropriate action to take.

Your active involvement before, during and after the treatment will establish the treatment outcome. It is vital that you adhere to the pre-treatment skin/body care regime and homecare protocols as instructed by your advanced aesthetic practitioner.

Client Name _____

Please initial those that apply:

_____ I have provided full and accurate medical information details to my advanced aesthetic practitioner.

_____ I am not actively trying to conceive, pregnant or lactating.

_____ I do not have any active Herpes simplex (cold sores). Prophylactic antiviral medication or topical antiviral cream may be used up to 2 days before treatment and up to 5 days after treatment.

_____ I agree to follow the advice of my advanced aesthetic practitioner regarding the use of active skin or body product 3-5 days prior to treatment.

_____ I confirm that I have not used Isotretinoin in the past 6 -12 months in line with guidance from my advanced aesthetic practitioner.

_____ I agree to avoid direct sun exposure before and after treatment as advised by my advanced aesthetic practitioner

_____ I agree to apply a UVA/UVB sunscreen daily (minimum SPF30+).

_____ I agree to notify my advanced aesthetic practitioner of any concerns.

_____ I understand that the following contra-actions/adverse reactions may occur:

- | | |
|---|--|
| • Prolonged erythema | • Infection |
| • Hyperaemia | • Activation of herpes simplex |
| • Blanching | • Allergic reaction |
| • Frosting | • Urticaria |
| • Pigmentary changes | • Papules |
| • Post-inflammatory hyperpigmentation (PIH) | • Overtreatment (deeper resurfacing than intended) |
| • Swelling | • Scarring |
| • Compromised healing | • Changes in skin texture |
| • Acne | |

_____ I understand that tactile and thermal tests must be performed in order to ascertain my levels of sensitivity as failure to accurately discern the variances may prevent treatment.

_____ I understand that product tests may be required at least 24-48 hours prior to treatment as appropriate

_____ I understand the necessity for a cooling off period between initial consultation and treatment

_____ I understand that treatment results are varied and not guaranteed and reliant upon following aftercare recommendations given to me by my advanced aesthetic practitioner

_____ I have discussed my expectations and goals with my advanced aesthetic practitioner and I understand that more than one treatment may be required to achieve the desired outcome.

_____ I have discussed the treatment limitations and possible complications and associated risks with my advanced aesthetic practitioner.

_____ I have discussed alternative treatments with my advanced aesthetic practitioner

_____ I acknowledge the possibility of an adverse reaction to treatment and take sole responsibility for any medical care that may become necessary. I agree to immediately inform the practitioner performing the treatment of any adverse effects.

_____ My advanced aesthetic practitioner has provided treatment information and answered all of the questions I have concerning this treatment.

_____ I fully understand all of the above information and agree to proceed with the proposed treatment plan.

Client name: _____

Client signature: _____

Advanced aesthetic practitioner name: _____

Advanced aesthetic practitioner signature: _____

Date: _____

Photographs/multimedia images of the treatment area are taken before each treatment and after each treatment to monitor and document progress.

I hereby authorise _____ to take photographs of the area before and after each treatment and after my treatment series.

Client signature: _____ Date: _____

Photographs/multimedia images are useful tools for educating others about conditions such as your own.

I hereby authorise _____ to use or show photographs of the treatment area(s) I have received for the purpose of education.

Client signature: _____ Date: _____

Post-treatment instructions

In order to achieve the best results possible, it is important that you read and understand the following instructions. Your advanced aesthetic practitioner will discuss the required post-treatment protocols with you following treatment; these instructions must be adhered to as advised by your advanced aesthetic practitioner.

1. Your advanced aesthetic practitioner will advise you of the expected treatment recovery time and skin response
2. Use cool compresses to minimise redness, swelling and any discomfort as advised
3. Use only the topical preparations and products on the treatment area for the recommended duration as advised by your advanced aesthetic practitioner
4. Hot showers/baths, heat treatments and perfumed products must be avoided for 24-48 hours
5. Avoid make-up for 24-48 hours
6. Avoid activities that might cause sweating such as vigorous exercise
7. Avoid contact with water
8. Avoid sun exposure and use a minimum SPF30 and UVA/UVB protection daily
9. Your advanced aesthetic practitioner will advise you of suitable post treatment personal hygiene practices
10. Your advanced aesthetic practitioner will advise you of suitable post care treatment regime including appropriate products for the area treated

Additional information:

I accept the results of the treatment performed today and I understand and agree to adhere to the above instructions. I agree to contact my advanced aesthetic practitioner with any additional questions I may have.

Client name: _____

Client signature: _____ Date: _____

Advanced aesthetic practitioner name: _____

Advanced aesthetic practitioner signature: _____ Date: _____

Lecturer name: _____

Lecturer signature: _____ Date: _____

Skin Sensitivity Tests

Client information

Please read carefully and only sign if you are in full agreement with its contents.

I _____ confirm that I have received the required skin sensitivity tests prior to chemical skin peeling treatment and have had a sufficient cooling off period to make an informed choice and confirm that I am willing to proceed with the treatment as agreed.

You should note that if the learner is unable to explain to you the treatment contra-actions and contra-indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

It is your responsibility and not that of the learner to consult your GP or Consultant.

I hereby indemnify the learner against any adverse reaction sustained as a result of the treatment.

Client signature: _____ Date: _____

Learner signature: _____ Date: _____

Treatment evaluation and reflective practice

Treatment evaluation and reflective practice	<p>Treatment evaluation and reflective practice should include, but is not limited to:</p> <ul style="list-style-type: none">• Rationale for the uses, benefits, and effects of chemical skin peeling products and technique(s) selected• Factors to consider when treatment planning, including (but not limited to), client's needs and expectations, contra-indications, skin characteristics, previous treatments and test results• Pain threshold and sensitivity variations• Organisation protocols for referring client for medical permission prior to treatment• Pre and post treatment advice• Treatment timing and intervals of treatments• Contra-actions, adverse reactions and appropriate complications management• Adaptation for future treatments with rationale• Client feedback and compliance with aftercare
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