

Case Study Consultation Form

UBT456 – Enhance Appearance using Plasma Pen Techniques

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"/>	Diabetes <input type="checkbox"/>
Birthmarks <input type="checkbox"/>	Permanent or semi-permanent make-up in the area <input type="checkbox"/>	History or present use of Melatonin <input type="checkbox"/>
History of skin cancer <input type="checkbox"/>	Haemophilia <input type="checkbox"/>	HIV, AIDS <input type="checkbox"/>
Hepatitis B or C <input type="checkbox"/>	Inappropriate skin colour for treatment <input type="checkbox"/>	Keloid scarring <input type="checkbox"/>
Keloid scarring <input type="checkbox"/>	Autoimmune diseases <input type="checkbox"/>	Lupus <input type="checkbox"/>
Lymphatic system disorders <input type="checkbox"/>	Oral and topical retinoids <input type="checkbox"/>	Oral and topical medication for Photo-Dynamic Therapy <input type="checkbox"/>
Oral and topical steroids <input type="checkbox"/>	Angina <input type="checkbox"/>	Pacemaker/defibrillator <input type="checkbox"/>
Vascular diseases <input type="checkbox"/>	Bleeding or clotting disorders <input type="checkbox"/>	Pigmentary disturbance <input type="checkbox"/>
Poorly controlled diabetes <input type="checkbox"/>	Porphyria <input type="checkbox"/>	Pregnancy <input type="checkbox"/>
Breast feeding <input type="checkbox"/>	Semi-permanent and permanent injectable filler products in the treatment area <input type="checkbox"/>	Active suntan <input type="checkbox"/>
Any conditions not covered by insurance policy <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Active inflammatory dermatoses <input type="checkbox"/>
Anxiety <input type="checkbox"/>	Bruises <input type="checkbox"/>	Current medications <input type="checkbox"/>
Cuts <input type="checkbox"/>	Epilation <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Herpes simplex <input type="checkbox"/>	History of scarring <input type="checkbox"/>	Recent IPL or Laser in the treatment area <input type="checkbox"/>
Large moles <input type="checkbox"/>	Long term anti-inflammatory use <input type="checkbox"/>	Non-steroidal anti-inflammatory drugs <input type="checkbox"/>
Piercings <input type="checkbox"/>	Poor mental and emotional state <input type="checkbox"/>	Prior cosmetic surgery <input type="checkbox"/>
Recent botulinum toxin injections or dermal fillers <input type="checkbox"/>	Recent cosmetic skin peels <input type="checkbox"/>	Sensitive or excessively reactive skin types <input type="checkbox"/>
Recent UV exposure <input type="checkbox"/>	Artificial tan <input type="checkbox"/>	Blood donation <input type="checkbox"/>
Varicose veins <input type="checkbox"/>		

Comments:

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

Active acne <input type="checkbox"/>	Inflammatory conditions (acute rheumatism, arthritis) <input type="checkbox"/>	Any condition already being treated by a GP or dermatologist <input type="checkbox"/>
Asthma <input type="checkbox"/>	Bell's palsy <input type="checkbox"/>	Inflamed/trapped/pinched nerve <input type="checkbox"/>
Medical oedema <input type="checkbox"/>	Nervous/psychotic conditions <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>
Recent operations <input type="checkbox"/>	Epilepsy <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 <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from anxiety, stress, depression and/or are clinically diagnosed?		
If yes, please specify:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Do you drink alcohol?		
If yes, how many units per week?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you trying to conceive, pregnant or lactating?		
If yes, please specify:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you:		
Due to have or having your menstrual period <input type="checkbox"/>	Menopausal <input type="checkbox"/>	
Post menopause <input type="checkbox"/>	Peri-menopausal <input type="checkbox"/>	
Additional details:		

Do you have any allergies?		
<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/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	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"/>	IPL	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin peeling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other treatment not listed	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"/>			
<i>If yes, please specify treatment details (to include treatment dates, frequency, results and client satisfaction with outcome):</i>					

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 home care products containing any of the following?

Exfoliating granules	<input type="checkbox"/>	Glycolic Acid	<input type="checkbox"/>	Lactic Acid	<input type="checkbox"/>
Other Alpha Hydroxy Acids	<input type="checkbox"/>	Vitamin A derivatives (Retinol)	<input type="checkbox"/>	Salicylic Acid	<input type="checkbox"/>

If yes, please specify skin reaction after use:

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?

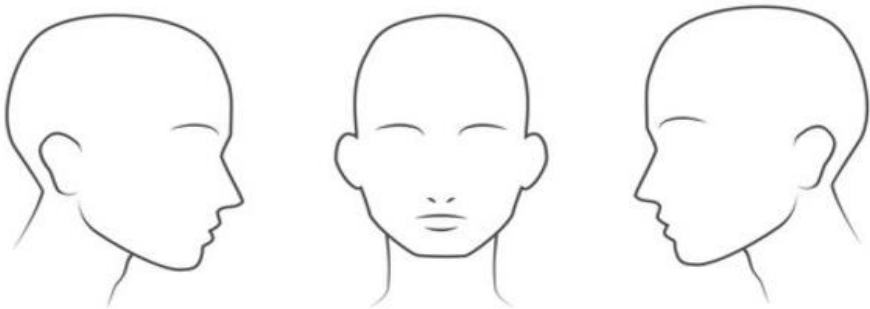
Details of any planned cosmetic/aesthetic procedures that may impact on the treatment

Please specify:

What specific skin/body concerns do you have?

What are your expectations of this treatment?

Skin/body assessment:						
Skin type	Excessively Oily	<input type="checkbox"/>	Congested	<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"/>
	Sensitive	<input type="checkbox"/>	Static wrinkles	<input type="checkbox"/>	Dynamic wrinkles	<input type="checkbox"/>
	Open pores	<input type="checkbox"/>	Pigmentation	<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"/>	Muscle laxity	<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"/>
	Seborrhoeic dermatitis	<input type="checkbox"/>	Other	<input type="checkbox"/>		
Epidermal thickness						
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						

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"/>	
	Additional comments:			
Treatment objectives:	Reduction of fine lines <input type="checkbox"/>	Blepharoplasty (eyelid lift upper and lower) <input type="checkbox"/>	Improvement of stretch marks <input type="checkbox"/>	
	Improvement of pigmentation variations <input type="checkbox"/>	Improved skin texture <input type="checkbox"/>	Skin tag removal (with GP permission) <input type="checkbox"/>	
	Removal of Dermatitis papulose nigra (with GP permission) <input type="checkbox"/>	Improved skin laxity <input type="checkbox"/>	Other <input type="checkbox"/>	
Proposed treatment plan – (detail where appropriate)				

Treatment details:			
Topical anaesthetic (if appropriate)			
Electrode probe used and batch number if appropriate			
Device settings and parameters for each area			
Skin/body reaction			
Client response			
Areas requiring modification:			
Post treatment products			
Post-treatment photograph taken:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Client feedback:	
Post-care/Home care advice given:	
Recommendations for follow-up/maintenance treatments	
<i>Comments:</i>	
Reflective practice	

Pre-treatment consent and Treatment information

The Plasma Pen treatment is a non-surgical treatment that uses a low temperature, high energy discharge to make a small wound in the skin to initiate an inflammatory response which encourages fibroblasts to repair the skin, help maintain or regain firmness and improve areas of pigmentation on specific areas of the face or body. During the treatment you may experience some mild to moderate discomfort, a sense of heat, pressure and momentary discomfort. Darkened dots or areas may become visible and crust or scab over, these will fade as the scab/crust naturally falls off following treatment. 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.

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 home care protocols as instructed by your advanced aesthetic practitioner.

Client Name _____

Please initial those that apply:

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

_____ I am not pregnant or lactating.

_____ I do not have any active Herpes simplex (cold sores).

_____ I am/am not taking/using prescribed/over the counter (OTC) prophylactic antiviral medication/topical antiviral cream.

Please delete as applicable. If answer is yes please confirm that the medication/antiviral cream is being taken in accordance with the patient information leaflet contained therein.

_____ I agree to avoid the use of active skin or body products 3-5 days prior to treatment.

_____ I confirm that I have not used Isotretinoin in the past 6 -12 months.

_____ I agree to follow the treatment protocol advised by my advanced aesthetic practitioner prior to treatment.

_____ I agree to avoid direct sun exposure.

_____ I agree to apply a 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:

- Erythema
- Hyperaemia
- Histamine reaction
- Anaphylaxis
- Bruising
- Burns
- Irritation
- Infections
- Pigmentary changes
- Trans-dermal water loss
- Compromised healing process
- Nausea
- Dizziness
- Papules
- Pustules
- Pain
- Inflammation
- Swelling
- Excessive oedema
- Prophylaxis herpetic infection
- Wounds
- Atrophic scarring
- Keloid scarring
- Fainting

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

_____ 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 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 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 packs/compresses to minimise redness, swelling and any discomfort
3. Avoid perfumes, deodorants, and face or body creams on the area for 24-48 hours
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 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 treatment products

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 Plasma Pen 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: _____