Case Study Consultation Form

UBT459 – Provide Radiofrequency Microneedling Techniques

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

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

Personal details:						
Age group:	Under 20 ☐	20 – 29 ☐	30 – 39 ☐	40 – 49 ☐	50 – 59 ☐	60+ ☐
Occupation:						
Lifestyle:	Active ☐			Sedentary ☐		
Details of activity:						
GP Address:						

Contra-indications that prevent (absolute contra-indications) – *(Select if/where appropriate):*					
Anticoagulant medication	☐	Acne	☐	Active inflammation and/or infection in the treated area	☐
Haemophilia	☐	Epilepsy	☐	Vascular disease	☐
Diseases stimulated by heat	☐	Auto-immune conditions	☐	Cancer-related treatments	☐
Contagious skin diseases	☐	Current or history of cancer and pre-malignant condition	☐	Recurrent Herpes Simplex in treatment area	☐
Dysfunctions of the nervous system	☐	Degenerative neurological disorders	☐	Heart disease/disorder	☐
History of keloid scarring	☐	Impaired kidney function	☐	Impaired liver function	☐
Current IVF procedure	☐	Metal implants in the treated area (excluding dental implants)	☐	Pacemaker/internal defibrillator	☐
Photosensitive medication	☐	Recent scar tissue in treatment area	☐	Recent pregnancy or breast feeding	☐
Pregnancy	☐	Recent skin peeling	☐	Current use of Skin thinning medication (steroids, isotretinoin, Roaccutane)	☐
Immunosuppressant medication/treatment	☐	Rosacea in the treatment area	☐	Swelling in the treatment area	☐
Thrombosis	☐	Thrombophlebitis	☐	Uncontrolled disorder of the thyroid gland	☐
Undiagnosed lumps	☐	Varicose veins	☐	Other	☐

Contra-indications that restrict treatment (relative contra-indications) – *(Select if/where appropriate):*		
Bruising ☐	Cosmetic skin needling ☐	Microdermabrasion ☐
Abrasions ☐	Cuts ☐	Botulinum toxin or neuromodulation injections in the treatment area (within the first 2 weeks) ☐
Epilation ☐	Hernia or mesh hernia repair ☐	Scars/wounds ☐
Intense pulsed light (IPL) or laser ☐	Large moles ☐	Prior to cosmetic surgery ☐
Chemical peel ☐	Scarification in the treatment area ☐	Sensitive or excessively reactive skin types ☐
Silicone implants or dermal filler injections in the treatment area ☐	Telangiectasia ☐	Recent UV exposure ☐
Active suntan ☐	Artificial tan ☐	Blood donation ☐
Varicose veins ☐	Active inflammatory dermatoses (Psoriasis) ☐	Anxiety ☐
Current medications ☐	History of circulatory disorders ☐	Epilepsy ☐
Implants or IUDS (specific to devise used) ☐	Poor mental and emotional state ☐	Previous use of isotretinoin (for within 6 months or in line with manufacturers' guidance) ☐
Overactive thyroid gland ☐	Metal piercings ☐	Recent surgical procedure ☐
Rosacea ☐	Supplements and herbal remedies ☐	Other ☐
Comments:		

Contra-indications that require medical referral: *Restricted (relative) contra-indications where further consideration may be required to ensure that the client is safe to receive the treatment, or any condition already being treated by General Practitioner (GP)/dermatologist.*
Please specify:

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 ☐	Informed consent ☐

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 ☐	Currently on the contraceptive pill ☐	Menopausal ☐
Post menopause ☐	Peri-menopausal ☐	Currently taking HRT ☐

Additional details including date of last menstrual period if relevant:

Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐
Do you or have you ever suffered from anaphylaxis?		
If yes, please provide details:	Yes ☐	No ☐
How long since your last exposure to sun, sunbed or artificial tan?		
Please specify details:		
Are you currently sun/wind burnt, or do you have an active/artificial tan?	Yes ☐	No ☐
Do you wear a sun protectant?		
If yes, please specify SPF/frequency of application:	Yes ☐	No ☐
Do you suffer from Herpes simplex?		
If yes, please specify where outbreaks occur/frequency and likely triggers:	Yes ☐	No ☐

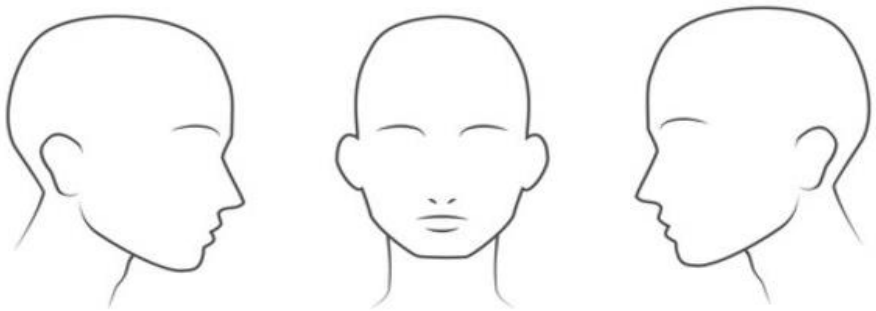
Have you had any of the following?					
Botox/neuromodulation/anti-wrinkle injections	Yes ☐	No ☐	Injectable dermal fillers	Yes ☐	No ☐
Light based therapy	Yes ☐	No ☐	Depilatory treatments	Yes ☐	No ☐
Laser/IPL	Yes ☐	No ☐	Electrolysis	Yes ☐	No ☐
Microdermabrasion	Yes ☐	No ☐	Facial surgery	Yes ☐	No ☐
Skin needling	Yes ☐	No ☐	Exfoliation	Yes ☐	No ☐
Skin peeling	Yes ☐	No ☐	Dermaplaning	Yes ☐	No ☐
Intralipolysis	Yes ☐	No ☐	Cryolipolysis	Yes ☐	No ☐
Cavitation	Yes ☐	No ☐	Body surgery	Yes ☐	No ☐
Radiofrequency	Yes ☐	No ☐	Ultrasound	Yes ☐	No ☐
Surgery in the area	Yes ☐	No ☐	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?		
If yes, please specify details:	Yes ☐	No ☐
Have you taken/used Isotretinoin or any other skin medication within the last 6-12 months?		
If yes, please specify details:	Yes ☐	No ☐
Have you taken/used any tyrosinase inhibitors or enhancers to reduce pigmentation or enhance tanning?		
If yes, please specify details:	Yes ☐	No ☐

Do you use or have you ever used home care products containing any of the following?					
Exfoliating granules	☐	Glycolic Acid	☐	Lactic Acid	☐
Other Alpha Hydroxy Acids	☐	Vitamin A derivatives (Retinol)	☐	Salicylic Acid	☐
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	Excessively Oily ☐	Excessively Dry ☐	Fitzpatrick scale I ☐
	Fitzpatrick scale II ☐	Fitzpatrick scale III ☐	Fitzpatrick scale IV ☐
	Fitzpatrick scale V ☐	Fitzpatrick scale VI ☐	Glogau photo damage ☐
Skin/body characteristics/ conditions	Uneven pigmentation ☐	Hyper pigmentation ☐	Hypo pigmentation ☐
	Active acne ☐	Static wrinkles ☐	Dynamic wrinkles ☐
	Open pores ☐	Uneven texture ☐	Scarring ☐
	Vascular lesions ☐	Irregularities ☐	Itching/Pruritus ☐
	Stretchmarks ☐	Skin laxity ☐	Papules/pustules ☐
	Psoriasis ☐	Scleroderma ☐	Graft versus host disease ☐
	Leishmaniasis ☐	Temporal arteritis ☐	Trauma ☐
	Seborrheic dermatitis ☐	Hereditary factors ☐	Oily ☐
	Dry ☐	Combination ☐	Dehydrated ☐
	Congested ☐	Sensitive ☐	Other ☐
Characteristics and history of scars/stretchmarks present	Mature ☐	Immature ☐	Superficial ☐
	Deep ☐	Atrophic ☐	Hypertrophic/keloid ☐
	Box scars ☐	Ice-pick scars ☐	Rolling ☐
	Insect bites ☐	Post acne ☐	Chickenpox ☐
	Trauma ☐	Surgery ☐	Burns ☐
	Non suicidal self-injury (NSSI) ☐	Dermatillomania ☐	Other ☐

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	

<table>
<tr><td rowspan="5">Skin sensitivity tests</td><td>Date:</td><td colspan="2"></td></tr>
<tr><td>Area(s) tested:</td><td colspan="2"></td></tr>
<tr><td>Thermal test:</td><td>Positive ☐</td><td>Negative ☐</td></tr>
<tr><td>Tactile test:</td><td>Positive ☐</td><td>Negative ☐</td></tr>
<tr><td colspan="3">Additional comments:</td></tr>
<tr><td rowspan="5">Treatment objectives:</td><td>Reduction of fine lines ☐</td><td>Skin rejuvenation ☐</td><td>Improvement of stretch marks ☐</td></tr>
<tr><td>Improvement of pigmentation variations ☐</td><td>Improved skin texture ☐</td><td>Improvement of superficial blemishes ☐</td></tr>
<tr><td>Improvement of skin hydration ☐</td><td>Improved skin laxity ☐</td><td>Remodelling of scar tissue ☐</td></tr>
<tr><td>Stimulation of glycosaminoglycans (GAGS) ☐</td><td>Increased dermal volume ☐</td><td>Minimised congestion ☐</td></tr>
<tr><td>Other ☐</td><td></td><td></td></tr>
<tr><td>Proposed treatment plan – (detail where appropriate)</td><td colspan="3">  </td></tr>
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	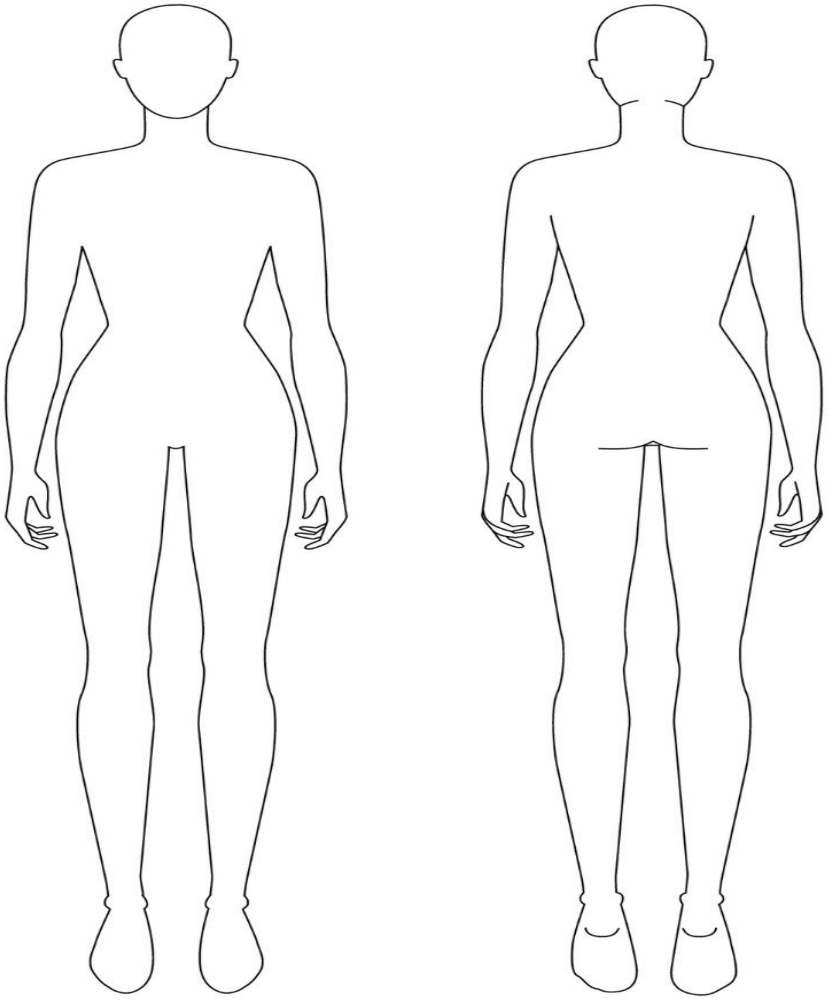		
Pre-treatment photograph/image taken:	Yes ☐	No ☐	
Comments:			

Treatment details:			
Details of skin preparation including protection of vulnerable areas			
Rationale for equipment and accessories selected			
Method of application and modifications where required			
Observed skin reaction and clinical endpoints			
Client tolerance and response to treatment including any soothing/cooling methods used			
Post treatment products in line with manufacturer guidance			
Post-treatment photographs/ images taken:	Yes ☐	No ☐	

Client feedback:	
Post-care/Home care advice given:	
Recommendations for follow up/maintenance treatments	
Comments:	

Pre-treatment consent and Treatment information

Radiofrequency microneedling is a non-surgical treatment that combines the benefits of both radiofrequency and microneedling techniques, introducing radiofrequency current into the dermis via microneedles which are inserted into the epidermis initiating a controlled wound response which triggers collagen and elastin production 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 sensitive or dry. You may also experience mild erythema (redness) and blood spotting to the area. Some clients may experience mild swelling and/or 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 home care protocols as instructed by your advanced aesthetic practitioner.

Client Name _____

Please initial those that apply:

_____ I have provided complete and accurate medical information details to my advanced aesthetic practitioner, and I agree to take responsibility for any omissions that might negatively impact the treatment procedure or results.

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

_____ I do not have any active Herpes simplex (cold sores) nor have I ever experienced any Herpes Simplex (cold sore) breakouts.

_____ I agree to follow the advice of my advanced aesthetic practitioner regarding 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 in line with guidance from my advanced aesthetic practitioner.

_____ I confirm that I have not used any tyrosinase enhancers in the past 4-6 weeks and will refrain from using any after treatment in line with guidance received 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:

- Histamine/allergic reaction
- Blistering
- Bruising
- Burns
- Excessive erythema
- Excessive oedema
- Excessive pain
- Hyperpigmentation
- Papules Pustules
- Irritation
- Infection
- Blood spotting
- Scarring

_____ I understand that tactile and thermal tests must be performed in order to ascertain my levels of sensitivity as failure to discern the variances accurately 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/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/media images 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/media images 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 minimize 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 tight clothes in the area
9. Avoid sun exposure and use a minimum SPF30 and UVA/UVB protection daily
10. Your advanced aesthetic practitioner will advise you of suitable post treatment personal hygiene practices
11. Your advanced aesthetic practitioner will advise you of suitable post care treatment regime including appropriate products for the area treated
12. Your advanced aesthetic practitioner will advise you of recommended future treatment/course of treatments and appropriate interval times

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 radiofrequency microneedling 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	*Treatment evaluation and reflective practice should include, but is not limited to:* • Indications for the use of radiofrequency microneedling treatment • 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 • Any adaptations/modifications required for future treatments with rationale • Client feedback and compliance with aftercare