Case Study Consultation Form

UBT465 – Provide radio frequency treatment

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 treatment – *(Select if/where appropriate):*					
Acne	☐	Active infection – bacterial, viral, fungal, herpetic	☐	Active inflammation or infection in the treated area	☐
Anticoagulant medication	☐	Autoimmune conditions (for example scleroderma)	☐	Current or history of cancer/cancer related treatments or premalignant condition	☐
Contagious skin diseases	☐	Degenerative neurological disorders	☐	Diabetes	☐
Diseases stimulated by heat	☐	Dysfunctions of the nervous system	☐	Heart disease/disorder	☐
Inflammations/infection in treatment area	☐	Internal defibrillator	☐	Impaired kidney function	☐
Impaired liver function	☐	IVF procedure	☐	Keloid scarring	☐
Lactation	☐	Metal implants in treatment area (excluding dental implants)	☐	Pacemaker/internal defibrillator	☐
Photosensitising medication	☐	Pregnancy/recent pregnancy or breastfeeding	☐	Recent scar tissue in treatment area	☐
Recent skin peeling	☐	Recurrent Herpes Simplex in treatment area	☐	Rosacea in treatment area	☐
Roaccutane use	☐	Steroidal medication	☐	Swelling in treatment area	☐
Thrombosis	☐	Thrombophlebitis	☐	Uncontrolled thyroid disorder	☐
Undiagnosed lumps	☐	Varicose veins	☐	Highly vascular conditions	☐
Comments:					

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Abrasions	☐	Neuromodulation injections/ dermal filler in the treatment area	☐	Bruises	☐
Cosmetic skin needling	☐	Cuts	☐	Crystal microdermabrasion	☐
Epilation treatment	☐	Excessively oily skin	☐	Herpes simplex	☐
IPL treatment	☐	Large moles	☐	Laser treatment	☐
Metal prostheses/implants	☐	Loss of skin sensitivity	☐	Microdermabrasion treatment	☐
Prior to cosmetic surgery	☐	Recent chemical peel	☐	Recent scars/wounds	☐
Sensitive/reactive skin type	☐	Silicone implants	☐	Telangiectasia	☐
Scarification of the treatment area	☐	UV exposure	☐	Varicose veins	☐
Comments:					

General:					
Active inflammatory dermatoses	☐	Anxiety	☐	Circulatory disorders	☐
Current medications	☐	Epilepsy	☐	Herbal remedies/supplements	☐
Implants/IUDs	☐	Isotretinoin use	☐	Poor mental/emotional state	☐
Over thyroid gland	☐	Irremovable piercings	☐	Recent surgery	☐
Rosacea (depending on area affected)	☐	Scars in treatment area	☐		
Comments:					

Contra-indications requiring medical permission:			
Active acne	☐	Areas of skin or moles that have uneven asymmetry, irregular, ragged or blurred boarders	☐
Raised moles or lesions	☐	Areas of skin that have uneven patchy colour or an altered diameter	☐

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 ☐	Peri-menopausal ☐	Menopausal ☐
Additional details including date of last menstrual period if relevant:		

Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐

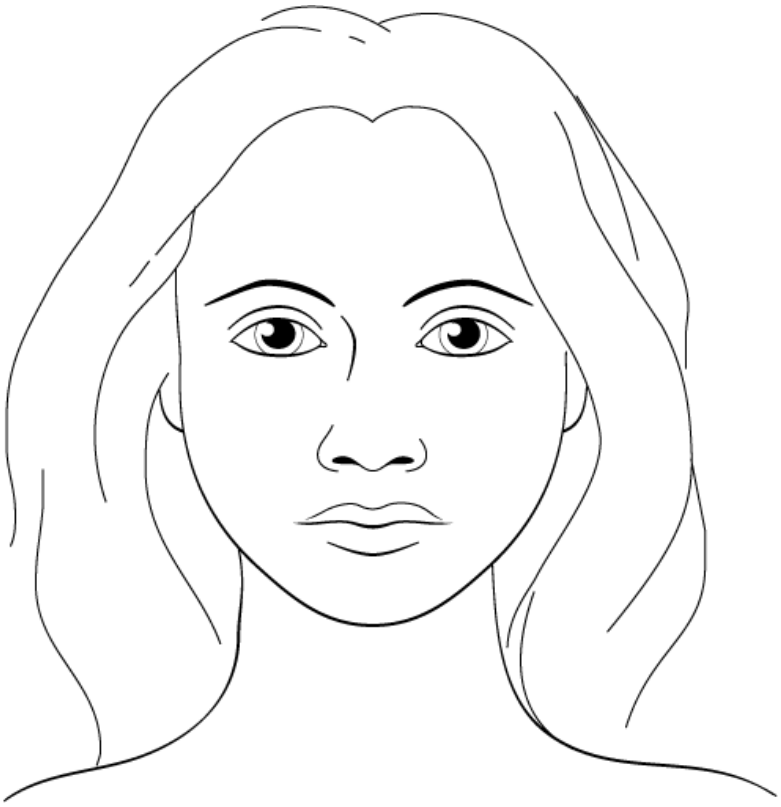
Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐

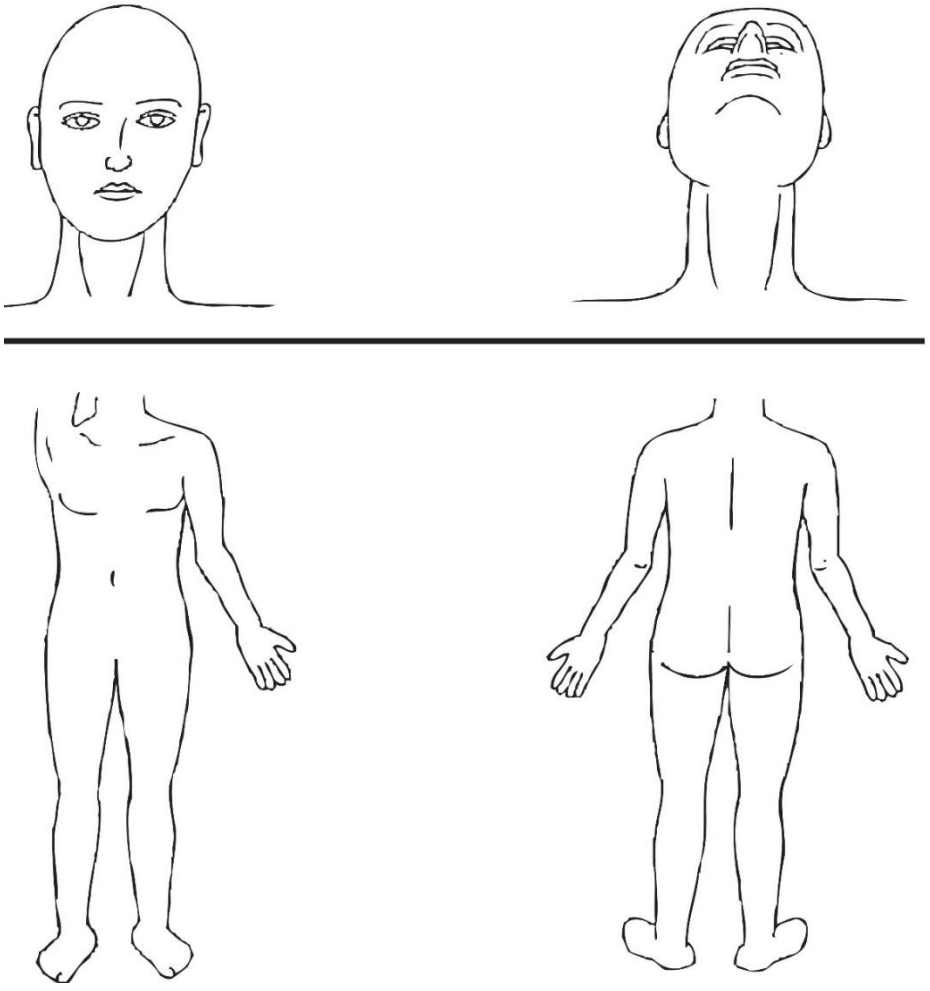
What is your level of sun exposure?		
Please specify details:		
Are you currently sun/wind burnt?	Yes ☐	No ☐
Do you wear a sun protectant?		
If yes, please specify SPF/frequency of application:	Yes ☐	No ☐
Do you suffer from Herpes simplex?		
If yes, please specify where outbreaks occur/frequency and likely triggers:	Yes ☐	No ☐

Have you had any of the following within the last 14 days?					
Neuromodulation injections/dermal fillers	Yes ☐	No ☐	Light based therapy	Yes ☐	No ☐
Depilatory treatments	Yes ☐	No ☐	Laser	Yes ☐	No ☐
Electrolysis	Yes ☐	No ☐	Microdermabrasion	Yes ☐	No ☐
Facial surgery	Yes ☐	No ☐	Skin needling	Yes ☐	No ☐
IPL	Yes ☐	No ☐	Skin peeling	Yes ☐	No ☐
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 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 ☐

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) ☐	
If yes, please specify frequency, skin reaction after use:		
What is your current daily skincare regime, including product details?		
Morning:		
Evening:		
What specific skin/body concerns do you have?		
What are your expectations of this treatment?		

Skin assessment:			
Skin type:	Normal ☐	Combination ☐	Dry ☐
	Oily ☐		
	Fitzpatrick scale I ☐	Fitzpatrick scale II ☐	Fitzpatrick scale III ☐
	Fitzpatrick scale IV ☐	Fitzpatrick scale V ☐	Fitzpatrick scale VI ☐
Skin condition:	Sensitive ☐	Dehydrated ☐	Mature ☐
	Broken capillaries ☐	Papules ☐	Open pores ☐
	Dark circles ☐	Pigmentation ☐	Scarring ☐
	Erythema ☐		
Skin hydration levels:			
Skin collagen levels:			
Skin healing capacity:	Brown pigmentation ☐	Pink/fades to white ☐	
			
	Additional comments:		

<table>
<tr><td rowspan="6">Skin sensitivity patch test:
(Documentary evidence of patch test to be included)</td><td>Date:</td><td colspan="2"></td></tr>
<tr><td>Area(s) tested:</td><td colspan="2"></td></tr>
<tr><td>Patch test reaction:</td><td>Positive ☐</td><td>Negative ☐</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>Treatment objectives:</td><td>Facial skin tightening ☐</td><td>Body skin tightening ☐</td><td>Treatment of cellulite ☐</td></tr>
<tr><td rowspan="5">Area(s) to be treated: –
(detail where appropriate)</td><td colspan="3">  </td></tr>
<tr><td>Cellulite deposits:</td><td colspan="2"></td></tr>
<tr><td>Fat deposits:</td><td colspan="2"></td></tr>
<tr><td>Body contour:</td><td colspan="2"></td></tr>
<tr><td>Skin laxity:</td><td colspan="2"></td></tr>
</table>

Pre-treatment visual media images taken:	Yes ☐	No ☐	
Comments:			

Treatment details – *(including client reaction to treatment and treatment parameters):*			
Current intensity:			
Duration of current flow:			
Areas requiring modification:			
Reaction levels:			
Skin reaction to treatment:			
Post-treatment visual media taken:	Yes ☐	No ☐	
Client feedback:			
Post-care/Home care advice given:			
Comments:			

Pre-treatment consent and treatment information

The radio frequency treatment is designed to improve skin tone and texture and to improve body contours. During the treatment you may experience a gradual warming sensation and your skin may turn red. This will fade following treatment, but you should tell your advanced aesthetic practitioner about the sensations you experience during treatment.

Immediately following treatment your skin may feel dry and tight. You may also experience mild erythema (redness) for 2-3 days.

Your active involvement before, during and after the treatment will establish the treatment outcome. It is vital that you adhere to the pre-treatment skincare regime and homecare 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). Prophylactic antiviral medication or tropical antiviral cream may be used up to 2 days before treatment and up to 3 days after treatment.

_____ 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 agree not to receive any of the following on the treatment area 1 week prior to treatment – Neuromodulation injections/injectable dermal filers or needling treatments.

_____ I agree not to receive any of the following on the treatment area 2 week prior to treatment – bleaching, electrolysis, depilation, facial treatments using AHA/BHA/Vitamin A, Hair colouring, IPL/Laser for skin rejuvenation, IPL/Laser for hair removal, light therapy, microdermabrasion.

_____ I agree to avoid the use of any prescribed topical such as Retin A, Salicylic Acid a minimum of 2 weeks prior to treatment.

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

_____ I confirm that I have not used Isotretinoin in the past 6 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 avoid any heat treatment immediately prior to treatment.

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

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

- Oversensitivity of treated area
- Blistering
- Bruising
- Open sores
- Swelling
- Fat atrophy leading to sunken treated areas
- Burns
- Erythema
- Excessive oedema
- Excessive pain
- Numbness
- Dizziness
- Fainting
- Itching/irritation
- Skin pigmentation
- Scarring
- Infections

_____ I understand that thermal/tactile tests must be performed in order to ascertain my levels of sensitivity.

_____ I understand that a patch test must be performed where there is the possibility of an allergy and when treatment products are changed.

_____ I understand that treatment results are varied and not guaranteed.

_____ I have discussed my expectations and goals with my advanced aesthetic practitioner.

_____ I have discussed the treatment limitations and possible complications 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.

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. Avoid additional heat treatment such as saunas, steam rooms, sun beds for 48 hours as excess heat can lead to discomfort, inflammation and irritation
3. Immediately following treatment, it is essential that you apply a broad-spectrum physical sunscreen (minimum SPF30). This must be reapplied according to manufacturer's instructions
4. Avoid direct sun exposure for 48 hours following treatment
5. Avoid strenuous/excessive exercise for 24 hours to prevent overheating/increased blood circulation
6. Increase water intake to at least 2 litres per day
7. Avoid the use of glycolic acid, retinol, AHA/BHA products for at least 24-48 hours
8. Use post-treatment products as instructed by your advanced aesthetic practitioner
9. Your advanced aesthetic practitioner will advise you of ongoing treatment recommendations and suitable treatments which may be used in conjunction with radio frequency treatment

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/patch test(s) 24-48 prior to radio frequency 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 radio frequency 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