Case Study Consultation Form

UBT466 – Provide cosmetic skin needling treatments

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):*					
Active acne	☐	Allergy to surgical grade stainless steel	☐	Anticoagulant medication	☐
Blood borne diseases	☐	Contagious skin diseases	☐	Hypersensitive skin	☐
Haemophilia	☐	Inflammation/swelling	☐	Isotretinoin use in the last 6 months	☐
Open wound(s)	☐	Photosensitising medication	☐	Recent scar tissue	☐
Rosacea	☐	Skin cancer	☐	Undiagnosed lumps	☐
Comments:					

Contra-indications that restrict treatment – *(Select if/where appropriate):*					
Abrasions	☐	Active inflammatory dermatoses	☐	Anxiety	☐
Recent neuromodulation injections/dermal fillers	☐	Bruises	☐	Current medications	☐
Cuts	☐	Direct sun exposure in last 24 hours	☐	Diabetes	☐
Epilation treatment	☐	Epilepsy	☐	Fever	☐
Supplements and herbal remedies	☐	Herpes Simplex	☐	History of hypertrophic scarring	☐
Hypersensitive or excessively reactive skin types	☐	IPL treatment	☐	Laser treatment	☐
Large moles	☐	Long-term anti-inflammatory use	☐	Piercings	☐
Poor mental/emotional state	☐	Prior to cosmetic surgery	☐	Recent microdermabrasion treatment	☐
Recent skin peeling treatment	☐	Reactive skin types	☐	Varicose veins	☐
Comments:					

Contra-indications requiring medical referral *(Select if/where appropriate):*		
Active acne ☐	Stretch marks ☐	Acute rheumatism or arthritis ☐
Any condition being treated by a GP/dermatologist ☐	Asthma ☐	Bell's palsy ☐
Inflamed/trapped /pinched nerve ☐	Medical oedema ☐	Nervous/psychotic conditions ☐
Osteoporosis ☐	Recent operations ☐	Epilepsy ☐
Areas of skin or moles that have uneven asymmetry, irregular, ragged or blurred borders ☐	Areas of skin or moles that have uneven, patchy colour or an altered diameter ☐	
Comments:		

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 under the care of a medical practitioner or other healthcare specialist in the last year?		
If yes, please specify:	Yes ☐	No ☐
Are you currently using any prescription 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:		

Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐
What is your level of sun exposure?		
If yes, please provide details:	Yes ☐	No ☐
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/injectable 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):					

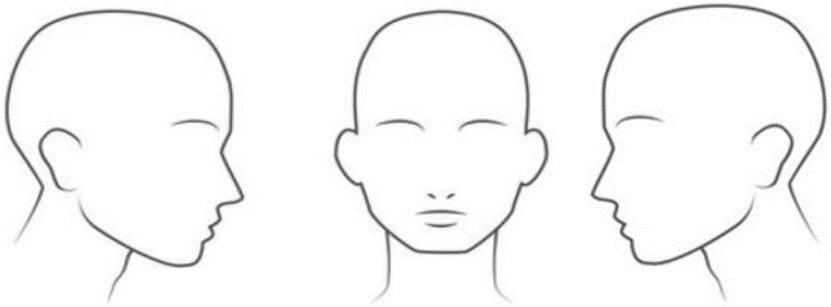
Do you use Retin A or any other prescription skincare products?		
If yes, please specify details:	Yes ☐	No ☐
Have you taken/used Isotretinoin or any other skin medication within the last 6-12 months?		
If yes, please specify details:	Yes ☐	No ☐

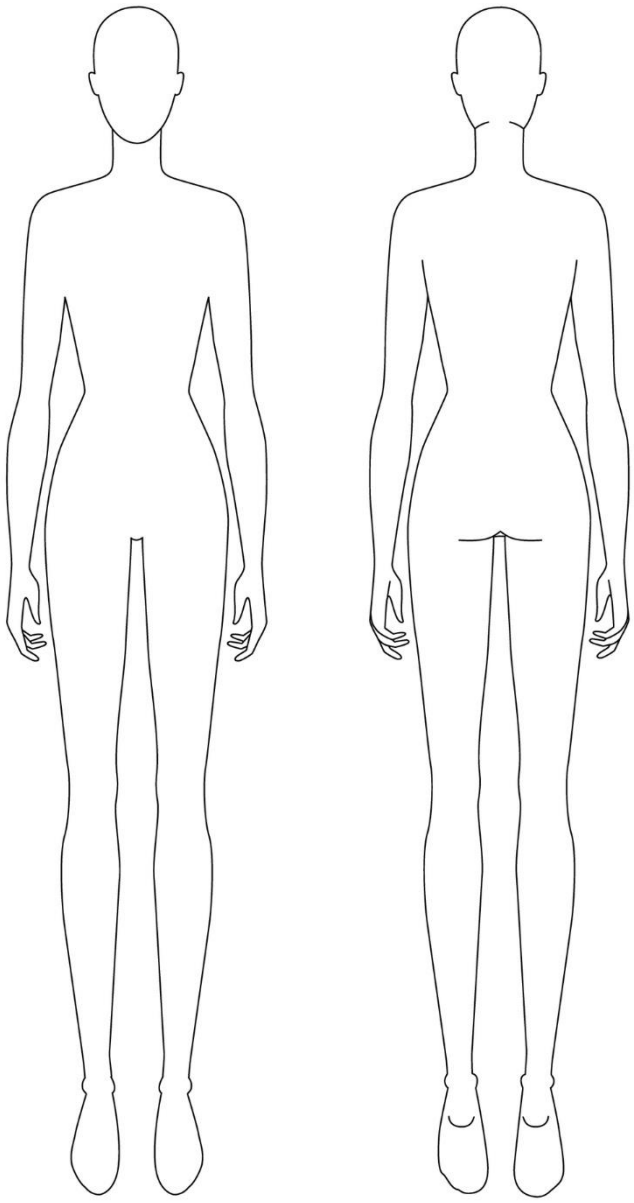
Do you use or have you ever used home care products containing any of the following?		
Exfoliating granules ☐	Glycolic Acid ☐	Lactic Acid ☐
Other Alpha Hydroxy Acids ☐	Vitamin A derivatives (Retinol) ☐	
If yes, please specify frequency, skin reaction after use and when last used:		

What is your current daily skin, including product details?
Morning:
Evening:

What specific skin 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 ☐
	Glogau Scale I ☐	Glogau Scale II ☐	Glogau Scale III ☐
	Glogau Scale IV ☐		
Skin condition:	Sensitive ☐	Dehydrated ☐	Mature ☐
	Broken capillaries ☐	Papules ☐	Open pores ☐
	Dark circles ☐	Pigmentation ☐	Scarring ☐
	Erythema ☐		
Skin healing capacity:	Brown pigmentation ☐	Pink/fades to white ☐	
	Scarring history/detail:		
Skin thickness:	Thin ☐	Medium ☐	Thick ☐
Proposed treatment plan – (detail where appropriate)			
	Additional comments:		

			
	Additional comments:		
Skin sensitivity patch test: *(Documentary*	Date:		
	Area:		
	Patch test reaction:	Positive ☐	Negative ☐

evidence of patch test to be included)	*Additional comments:*		
Pre-treatment visual media images taken:	Yes ☐	No ☐	
Treatment objective:	Reduction in fine lines ☐	Improvement in skin condition ☐	Improvement in skin texture ☐
	Improvement in skin laxity ☐	Improvement in stretch marks ☐	
Treatment to include:	Needle unit size:	Up to 0.5mm – face ☐	Up to 1mm – body ☐
	Manual device:	Stamp ☐	Roller ☐
		Pen ☐	Automated needling device ☐
Comments:			

Treatment details – *(to include all products used, methods of use etc.):*			
Application areas:	Face ☐	Neck ☐	Chest ☐

	Back of hands ☐	Legs ☐	Abdomen ☐
Skin reaction to treatment:			
Post-treatment visual media images taken:	Yes ☐	No ☐	
Client feedback:			
Post-care/Home care advise given:			
Comments:			

Pre-treatment consent and Treatment information

The cosmetic skin needling treatment is designed to improve the overall appearance of the skin. During the treatment you may experience a pricking or stinging sensation and your skin may turn red or pinpoint bleeding may occur. 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 erythema (redness), heat in the tissues, minor swelling and pinpoint bleeding. Moderate flaking of the skin may also occur within a few days. Flaking skin must not be scratched, picked or pulled and exfoliant use must be avoided.

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 and consultation 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 topical antiviral cream may be used up to 2 days before treatment and up to 3 days after 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 weeks 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 medications 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 for a minimum of 2 weeks prior to treatment.

_____ I agree to avoid direct sun exposure.

_____ I agree to apply a sunscreen daily (minimum SPF30).

_____ I agree to avoid 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:

- Bruising
- Histamine reaction
- Erythema
- Tightness/discomfort
- Feeling of wind/sunburn
- Weeping
- Itching/irritation
- Localised allergic reaction
- Pinpoint bleeding
- Scabbing
- Infection
- Urticaria

_____ 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 contact 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. Wash hands before touching the treated area
3. Avoid the use of topical preparations/skincare products not designed for use following skin needling treatment for 24 hours
4. Avoid the use of active skincare containing AHAs, BHAs and retinoids for 48 hours
5. Avoid make-up for 24 hours
6. Avoid direct sun exposure for 5-10 days following treatment. Sunscreen cannot be applied immediately so it is essential to stay out of the sun
7. Avoid strenuous exercise for 24 hours to prevent overheating/increased blood circulation
8. Avoid saunas, steam rooms etc. as excess heat can lead to discomfort, inflammation, irritation etc
9. Avoid additional spa/beauty treatments for 24 hours
10. Increase water intake to at least 8 glasses per day
11. Your skin may begin to flake following treatment – **DO NOT PICK OR PEEL LOOSE SKIN**
12. Avoid the use of exfoliating products until the skin is fully healed
13. Avoid waxing/hair removal in treatment area until the skin is fully healed
14. Avoid contact with pets, polluted atmospheres/environments to reduce the risk of infection whilst skin healing takes place
15. Use post-treatment products as instructed by your advanced aesthetic practitioner
16. Your advanced aesthetic practitioner will advise you of ongoing treatment recommendations and suitable treatments which may be used in conjunction with cosmetic skin needling 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 patch test(s) 24-48 prior to cosmetic skin needling 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 cosmetic skin needling 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