Case Study Consultation Form

UBT467 – Provide 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 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Occupation:						
Lifestyle:	Active ☐			Sedentary ☐		
Details of activity:						
GP Address:						

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

Contra-indications that require medical referral – *(Select if/where appropriate):*		
Active acne ☐	Radiation treatment ☐	Any condition already being treated by a GP or dermatologist ☐
Asthma ☐	Certain medications including anti-coagulants ☐	Diabetes ☐
Cardiac disease ☐	Renal disease ☐	Hepatic disease ☐
Renal disease ☐	Recent surgery ☐	Undiagnosed swelling in treatment area ☐
Nervous/psychotic conditions ☐		
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 ☐	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 ☐		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?		
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 ☐
If yes, please specify if/which prophylactic anti-viral is being taken or recommended:	Yes ☐	Yes ☐

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 ☐
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 ☐

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

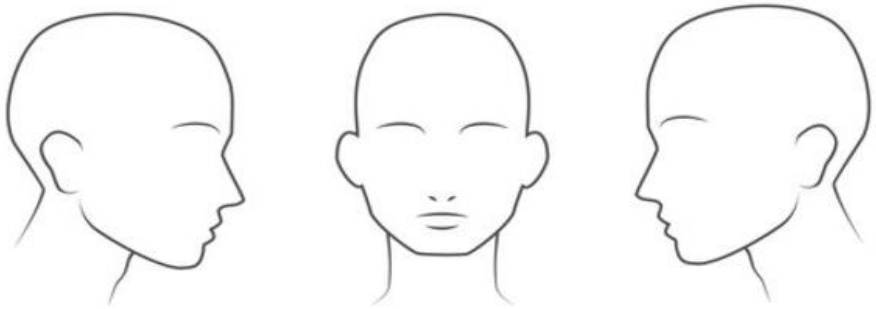
Please specify:

What specific skin/face/body concerns do you have?

What are your expectations of this treatment?

Skin/body assessment:						
Skin type and classification	Oily	☐	Dry	☐	Normal (balanced)	☐
	Combination	☐	Excessively oily	☐	Fitzpatrick scale I	☐
	Fitzpatrick scale II	☐	Fitzpatrick scale III	☐	Fitzpatrick scale IV	☐
	Fitzpatrick scale V	☐	Fitzpatrick scale VI	☐	Other	☐
Skin/body characteristics/ conditions	Glogau photo damage	☐	Hyper pigmentation	☐	Hypo pigmentation	☐
	Uneven pigmentation	☐	Static wrinkles	☐	Dynamic wrinkles	☐
	Open pores	☐	Sensitive	☐	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	☐	Mature	☐
	Acne prone	☐	Milia	☐	Dehydrated	☐
	Congested	☐	Comedones	☐	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	

<table>
<tr><td>Static and dynamic wrinkles</td><td colspan="3"></td></tr>
<tr><td>Additional comments</td><td colspan="3"></td></tr>
<tr><td rowspan="6">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>Product test:</td><td>Positive ☐</td><td>Negative ☐</td></tr>
<tr><td colspan="3">Additional comments:</td></tr>
<tr><td rowspan="2">Treatment objectives:</td><td>Skin rejuvenation ☐</td><td>Improvement of pigmentation variations ☐</td><td>Improved skin texture</td></tr>
<tr><td>Improvement of superficial blemishes ☐</td><td>Improvement of skin hydration ☐</td><td>Other ☐</td></tr>
<tr><td>Proposed treatment plan – (detail where appropriate)</td><td colspan="3">  </td></tr>
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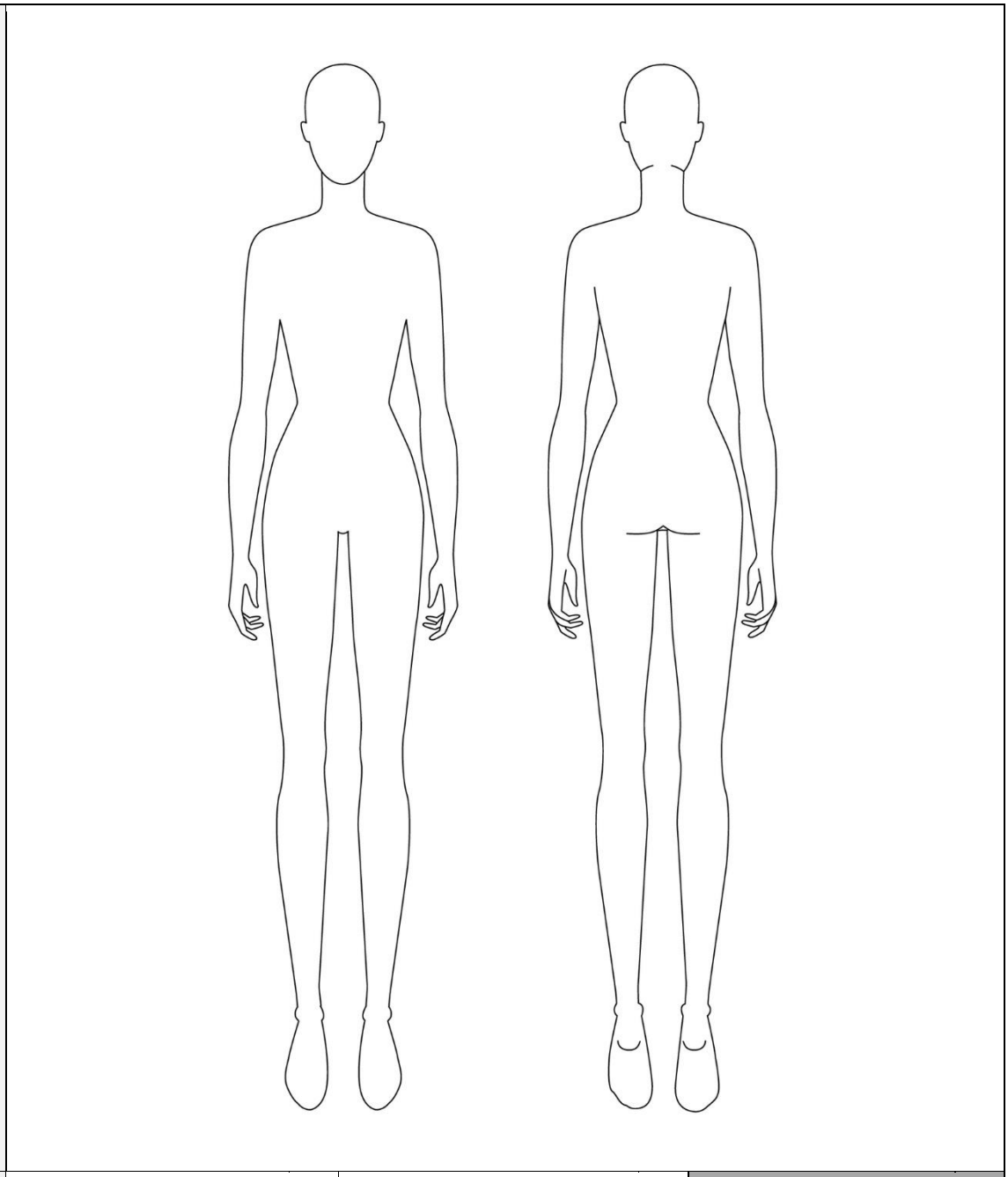

Pre-treatment photograph/visual media images taken:	Yes ☐	No ☐	

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/visual media 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

The skin peeling treatment is designed to exfoliate the superficial epidermis cells, the treatment uses 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, sensitive or sore. You may also experience mild erythema (redness). 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
- Frosting
- Pigmentary changes
- Swelling
- Acne
- Post-inflammatory hyperpigmentation (PIH)
- Discomfort/tingling/stinging
- Itching/irritation
- Burns
- Infection
- Activation of herpes simplex
- Overtreatment (deeper resurfacing than intended)
- Urticaria
- Papules
- Scarring
- Allergic reaction
- Changes in skin texture

_____ 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/visual media 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/visual media images of the area before and after each treatment and after my treatment series.

Client signature: _____ Date: _____

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

I hereby authorise _____ to use or show photographs/visual 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 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. Avoid direct sun exposure and sun tanning; for at least 4 weeks post skin peel
5. Hot showers/baths, heat treatments and perfumed products must be avoided for 24-48 hours
6. Avoid make-up for 24-48 hours
7. Avoid activities that might cause sweating such as vigorous exercise
8. Avoid swimming and vigorous exercise for up to 2 weeks
9. Avoid epilation, waxing or use of depilatories on the treated area for up to 2 weeks
10. Apply a physical and broad band spectrum sunscreen (UVA and UVB) with SPF 30+ minimum daily
11. Your advanced aesthetic practitioner will advise you of suitable post treatment personal hygiene practices
12. 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 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	Treatment evaluation and reflective practice should include, but is not limited to: • Rationale for the uses, benefits, and effects of 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