Case Study Consultation Form

UBT471 – 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 ☐	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 ☐	Diabetes ☐
Birthmarks ☐	Permanent or semi-permanent make-up in the area ☐	History or present use of Melatonin ☐
History of skin cancer ☐	Haemophilia ☐	HIV, AIDS ☐
Hepatitis B or C ☐	Inappropriate skin colour for treatment ☐	Keloid scarring ☐
Keloid scarring ☐	Autoimmune diseases ☐	Lupus ☐
Lymphatic system disorders ☐	Oral and topical retinoids ☐	Oral and topical medication for Photo-Dynamic Therapy ☐
Oral and topical steroids ☐	Angina ☐	Pacemaker/defibrillator ☐
Vascular diseases ☐	Bleeding or clotting disorders ☐	Pigmentary disturbance ☐
Poorly controlled diabetes ☐	Porphyria ☐	Pregnancy ☐
Breast feeding ☐	Semi-permanent and permanent injectable filler products in the treatment area ☐	Active suntan ☐
Any conditions not covered by insurance policy ☐	Abrasions ☐	Active inflammatory dermatoses ☐
Anxiety ☐	Bruises ☐	Current medications ☐
Cuts ☐	Epilation ☐	Epilepsy ☐
Herpes simplex ☐	History of scarring ☐	Recent IPL or Laser in the treatment area ☐
Large moles ☐	Long term anti-inflammatory use ☐	Non-steroidal anti-inflammatory drugs ☐
Piercings ☐	Poor mental and emotional state ☐	Prior cosmetic surgery ☐
Recent botulinum toxin injections or dermal fillers ☐	Recent cosmetic skin peels ☐	Sensitive or excessively reactive skin types ☐
Recent UV exposure ☐	Artificial tan ☐	Blood donation ☐
Varicose veins ☐		
Comments:		

Contra-indications that require medical referral – *(Select if/where appropriate):*					
Active acne	☐	Inflammatory conditions (acute rheumatism, arthritis)	☐	Any condition already being treated by a GP or dermatologist	☐
Asthma	☐	Bell's palsy	☐	Inflamed/trapped/ pinched nerve	☐
Medical oedema	☐	Nervous/psychotic conditions	☐	Osteoporosis	☐
Recent operations	☐	Epilepsy	☐		
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 to have or having your menstrual period ☐		Menopausal ☐
Post menopause ☐	Peri-menopausal ☐	
Additional details:		

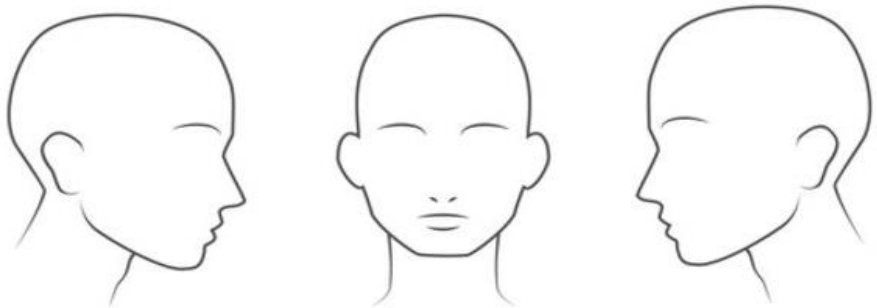
Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐
How long since your last exposure to sun, sunbed or artificial tan?		
Please specify details:		
Are you currently sun/wind burnt or do you have an active/artificial tan?	Yes ☐	No ☐
Do you wear a sun protectant?		
If yes, please specify 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/anti-wrinkle injections	Yes ☐	No ☐	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 ☐	Other treatment not listed	Yes ☐	No ☐
Intralipolysis	Yes ☐	No ☐	Cryolipolysis	Yes ☐	No ☐
Cavitation	Yes ☐	No ☐	Body surgery	Yes ☐	No ☐
Surgery in the area	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 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 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 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 ☐	Congested ☐	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 ☐
	Sensitive ☐	Static wrinkles ☐	Dynamic wrinkles ☐
	Open pores ☐	Pigmentation ☐	Scarring ☐
	Vascular lesions ☐	Irregularities ☐	Itching/Pruritus ☐
	Stretchmarks ☐	Skin laxity ☐	Muscle laxity ☐
	Psoriasis ☐	Scleroderma ☐	Graft versus host disease ☐
	Leishmaniasis ☐	Temporal arteritis ☐	Trauma ☐
	Seborrhoeic dermatitis ☐	Other ☐	
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			

<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="3">Treatment objectives:</td><td>Reduction of fine lines ☐</td><td>Blepharoplasty (eyelid lift upper and lower) ☐</td><td>Improvement of stretch marks ☐</td></tr>
<tr><td>Improvement of pigmentation variations ☐</td><td>Improved skin texture ☐</td><td>Skin tag removal (with GP permission) ☐</td></tr>
<tr><td>Removal of Dermatosis papulose nigra (with GP permission) ☐</td><td>Improved skin laxity ☐</td><td>Other ☐</td></tr>
<tr><td>Proposed treatment plan – (detail where appropriate)</td><td colspan="3">  </td></tr>
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	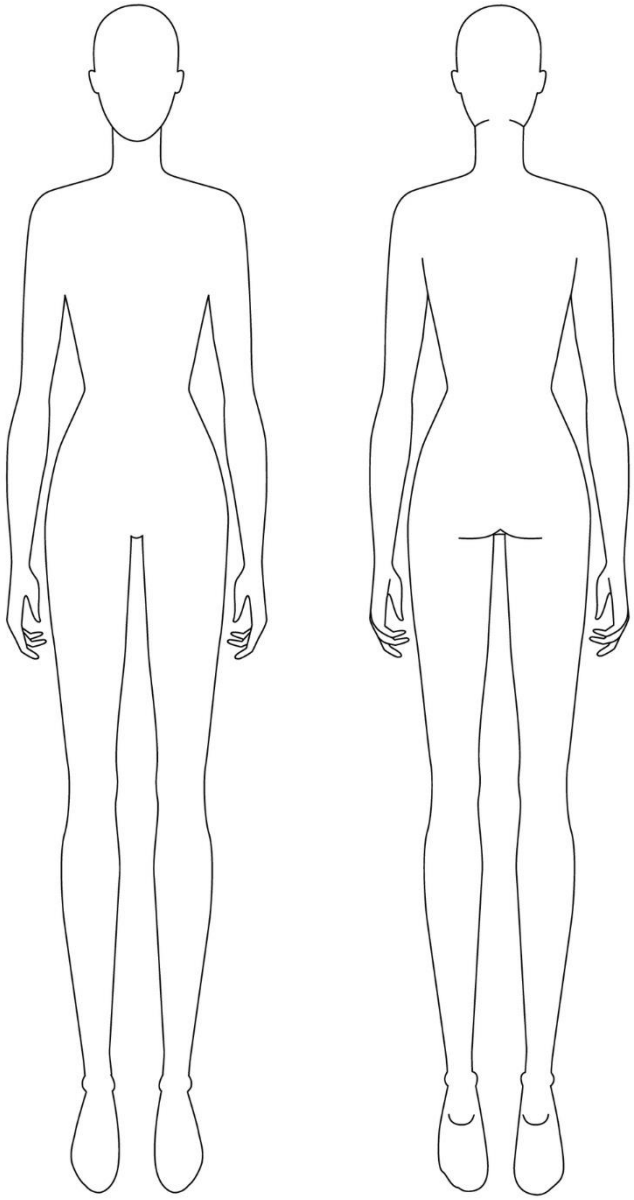		
Pre-treatment photograph taken:	Yes ☐	No ☐	
Comments:			

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 ☐	No ☐	

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