

Case Study Consultation Form

UBT473 – Enhance Appearance using Dermaplaning Techniques

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

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

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Occupation:						
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Details of activity:						
GP Address:						

Contra-indications that prevent or restrict treatment – (Select if/where appropriate):

Blood borne diseases <input type="checkbox"/>	Allergy to surgical grade stainless steel <input type="checkbox"/>	Contagious skin diseases <input type="checkbox"/>
Anticoagulant medication <input type="checkbox"/>	Extremely sensitive skin <input type="checkbox"/>	Haemophilia <input type="checkbox"/>
History of drugs with photosensitising potential <input type="checkbox"/>	Inflammations and swellings <input type="checkbox"/>	Open wounds <input type="checkbox"/>
Rosacea <input type="checkbox"/>	Severe active acne <input type="checkbox"/>	Skin cancer and undiagnosed lumps <input type="checkbox"/>
Recent scar tissue <input type="checkbox"/>	Any conditions not covered by insurance policy <input type="checkbox"/>	Cuts and abrasions <input type="checkbox"/>
Active inflammatory dermatoses (for example: psoriasis) <input type="checkbox"/>	Anxiety <input type="checkbox"/>	Bruises <input type="checkbox"/>
Current medication <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilation <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	History of scarring <input type="checkbox"/>	Intense pulsed light (IPL) or laser in the treatment area <input type="checkbox"/>
Recurrent Herpes Simplex <input type="checkbox"/>	Large moles <input type="checkbox"/>	Roaccutane/Isotretinoin use within 6 – 12 months <input type="checkbox"/>
Long term anti-inflammatory use <input type="checkbox"/>	Piercings <input type="checkbox"/>	Poor mental and emotional state <input type="checkbox"/>
Recent botulinum toxin injections or dermal fillers <input type="checkbox"/>	Recent dermabrasion or cosmetic skin peels <input type="checkbox"/>	Sensitive or excessively reactive skin types <input type="checkbox"/>
Supplements and herbal remedies <input type="checkbox"/>	Recent UV exposure <input type="checkbox"/>	Active suntan <input type="checkbox"/>
Artificial tan <input type="checkbox"/>	Varicose veins <input type="checkbox"/>	Prior cosmetic surgery <input type="checkbox"/>

Comments:

Contra-indications that require medical referral – (Select if/where appropriate):

Active acne <input type="checkbox"/>	Raised moles or lesions <input type="checkbox"/>	Areas of skin or moles that have uneven asymmetry, ragged or blurred borders <input type="checkbox"/>
Areas of skin or moles that have uneven asymmetry, ragged or blurred borders <input type="checkbox"/>	Areas of skin or moles that have uneven patchy colour or uneven diameter <input type="checkbox"/>	

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 <input type="checkbox"/>	Informed consent <input type="checkbox"/>
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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)?		
<i>If yes, please specify:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from anxiety, stress, depression and/or are clinically diagnosed?		
<i>If yes, please specify:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What are your stress levels? 1 to 10 (10 being the highest)	At work:	At home:
Do you smoke or vape?		
<i>If yes, how many per day?</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you drink alcohol?		
<i>If yes, how many units per week?</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you trying to conceive, pregnant or lactating?		
<i>If yes, please specify:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you:		
Due or having your menstrual period <input type="checkbox"/>	Peri-menopausal <input type="checkbox"/>	Menopausal <input type="checkbox"/>
Post menopause <input type="checkbox"/>		
<i>Additional details:</i>		
Do you have any allergies?		
<i>If yes, please provide details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

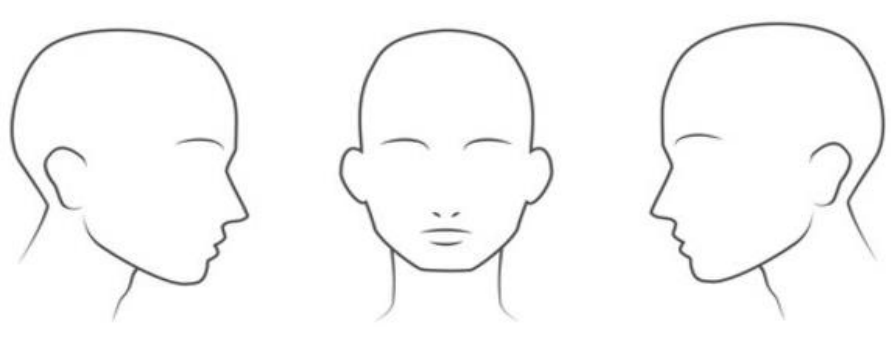
How long since your last exposure to sun, sunbed or artificial tan?		
<i>Please specify details:</i>		
Are you currently sun/wind burnt or do you have an active/artificial tan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wear a sun protectant?		
<i>If yes, please specify SPF/frequency of application:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from Herpes simplex?		
<i>If yes, please specify where outbreaks occur/frequency and likely triggers:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If yes, please specify if prophylactic anti-viral is being taken:</i>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

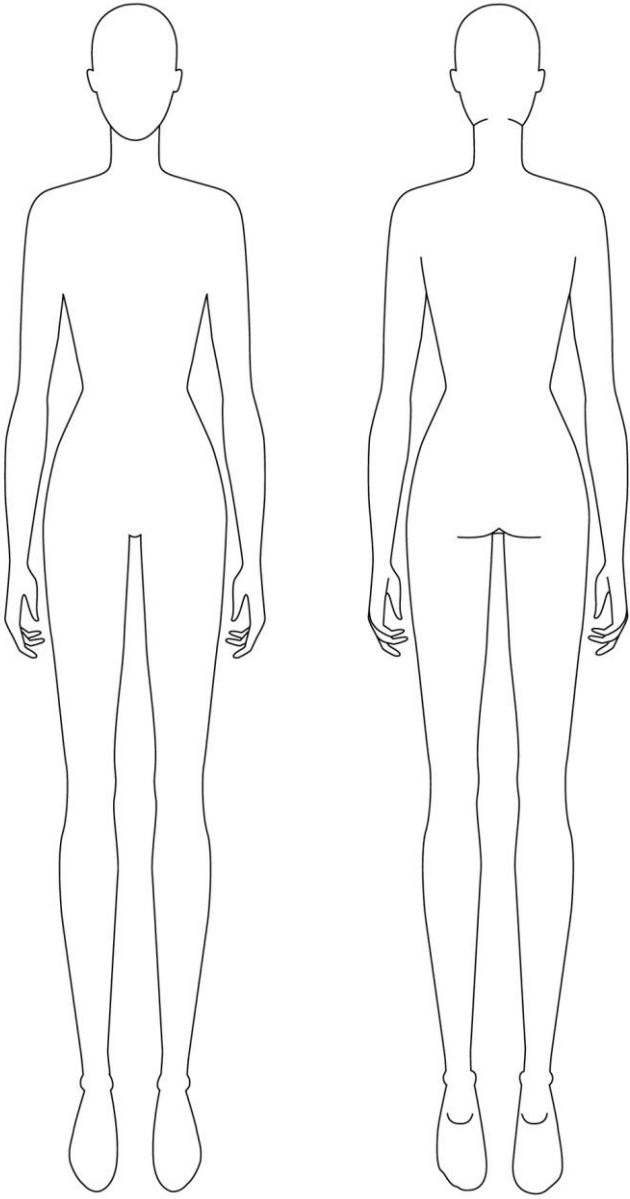
Have you had any of the following within the last 14 days?					
Botox/anti-wrinkle injections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Injectable dermal fillers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Light based therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depilatory treatments	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Laser	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Electrolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Microdermabrasion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Facial surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin needling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	IPL	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin peeling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other treatment not listed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If yes, please specify treatment details (to include treatment dates, frequency, results and client satisfaction with outcome):</i>					

Do you use Retin A or any other prescription skincare products?		
<i>If yes, please specify details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you taken/used Isotretinoin within the last 6-12 months?		
<i>If yes, please specify details:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you use home care products containing any of the following?		
Exfoliating granules <input type="checkbox"/>	Glycolic Acid <input type="checkbox"/>	Lactic Acid <input type="checkbox"/>
Other Alpha Hydroxy Acids <input type="checkbox"/>	Vitamin A derivatives (Retinol) <input type="checkbox"/>	Salicylic Acid <input type="checkbox"/>
<i>If yes, please specify skin reaction after use:</i>		
What is your current daily skin regime, including product details?		
Morning:		
Evening:		
What other aesthetic skin treatments/products have been used to prepare the area for treatment?		
Details of any previous or planned cosmetic procedures in the area including anti-wrinkle injections		
<i>Please specify:</i>		
What specific skin concerns do you have?		
What are your expectations of this treatment?		

Skin assessment:						
Skin type	Excessively Oily	<input type="checkbox"/>	Congested	<input type="checkbox"/>	Fitzpatrick scale I	<input type="checkbox"/>
	Fitzpatrick scale II	<input type="checkbox"/>	Fitzpatrick scale III	<input type="checkbox"/>	Fitzpatrick scale IV	<input type="checkbox"/>
	Fitzpatrick scale V	<input type="checkbox"/>	Fitzpatrick scale VI	<input type="checkbox"/>	Other	<input type="checkbox"/>
Skin characteristics/ conditions	Glogau photo damage	<input type="checkbox"/>	Hyper pigmentation	<input type="checkbox"/>	Hypo pigmentation	<input type="checkbox"/>
	Sensitive	<input type="checkbox"/>	Static wrinkles	<input type="checkbox"/>	Dynamic wrinkles	<input type="checkbox"/>
	Open and closed comedones	<input type="checkbox"/>	Papules	<input type="checkbox"/>	Pustules	<input type="checkbox"/>
	Nodules	<input type="checkbox"/>	Cysts	<input type="checkbox"/>	Open pores	<input type="checkbox"/>
	Pigmentation irregularities including post inflammatory	<input type="checkbox"/>	Vascular lesions	<input type="checkbox"/>	Skin laxity	<input type="checkbox"/>
	Irregularities	<input type="checkbox"/>	Poikiloderma of Civatte	<input type="checkbox"/>	Melasma	<input type="checkbox"/>
	Chloasma	<input type="checkbox"/>	Lentigo	<input type="checkbox"/>	Keloid formation	<input type="checkbox"/>
	Other	<input type="checkbox"/>				
Surface hydration levels						
Level of sensitivity (vascular)						
Thickness/density of skin						
Epidermal thickness						
Skin texture						
Healing capacity						
Surface hydration levels						
Skin laxity						
Type of scarring						
Type of lesions/irregularities						
Hair growth						
Hair characteristics						

Skin sensitivity patch test: (Documentary evidence of patch test to be included)	Date:			
	Area(s) tested:			
	Patch test reaction:	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Tactile test:	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	
	Additional comments:			
Treatment objectives:	Remove vellus hair from the surface of the epidermis on the face or body <input type="checkbox"/>	Remove excess dead skin cells from the surface of the epidermis on the face or body <input type="checkbox"/>	Improve the appearance of the skin surface and texture <input type="checkbox"/>	
	Minimise the appearance of scars <input type="checkbox"/>	Improve skin radiance <input type="checkbox"/>	Even out skin tone and colour <input type="checkbox"/>	
	Improve absorption of products and treatments <input type="checkbox"/>	Other <input type="checkbox"/>		
Proposed treatment plan – (detail where appropriate)				

			
Pre-treatment photograph taken:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<i>Comments:</i> 			

Treatment details:		
Select blade size and record batch number and expiry date		
Select product/serum if appropriate		
Adjust angle, direction and pressure appropriate to the area being treated		
Skin reaction		
Client response		
Areas requiring modification:		
Post treatment products/formulations		
Post-treatment photograph taken:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

Pre-treatment consent and Treatment information

The dermaplaning treatment is designed to enhance the appearance and general texture of the skin by removing vellus hair and excess dead skin from the surface of the skin. During the treatment, you may experience a gentle scraping sensation and slight sensitivity from skin support and stretch.

You may also experience slight tenderness and erythema (redness) in the area for 1-2 days after the treatment and some tightness and dryness.

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 topical antiviral cream may be used up to 2 days before treatment and up to 5 days after treatment.

_____ 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 i.e. Retin A, Salicylic Acid a minimum of 2 weeks prior to treatment.

_____ I agree to avoid the use of active skincare products and treatments 3-5 days prior to treatment.

_____ I confirm that I have not used Isotretinoin in the past 6 -12months.

_____ I agree to follow the treatment protocol advised by my advanced aesthetic practitioner prior to treatment.

_____ I agree to avoid direct sun/sunbed 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 may occur:

- Dryness
- Dehydration
- Flaking
- Scratching or grazing
- Bleeding or scabbing

_____ I understand that 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 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 a number of treatments 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 and after each treatment to monitor and document progress.

I hereby authorise _____ to take photographs of the area before and after each treatment.

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. Avoid AHAs, BHAs and Retinoids for 48 hours
3. Avoid make-up for 24 hours
4. Wash hands before touching treated area
5. Avoid pets and unclean surfaces to reduce risk of infection
6. Avoid immediate vigorous exercise and other spa/beauty treatments
7. Avoid sun exposure, heat treatments, polluted atmospheres and topical preparations (except those recommended by the practitioner)
8. Provide advice on suitable post treatment products
9. Provide advice for ongoing/further dermaplaning treatment and other salon treatments which may be used in conjunction to maintain or maximise results with appropriate time frames

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/Patch Test

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 dermaplaning 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: _____