Case Study Consultation Form

UBT474 – Enhance Appearance using Scalp Micropigmentation 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):*					
Blood borne diseases	☐	Allergy to surgical grade stainless steel	☐	Contagious scalp and skin diseases	☐
Anticoagulant medication	☐	Extremely sensitive scalp/skin	☐	Haemophilia	☐
History of drugs with photosensitising potential	☐	Inflammations and swellings	☐	Open wounds	☐
Rosacea	☐	Severe active acne	☐	Skin cancer and undiagnosed lumps	☐
Internal auditory devices (Cochlear implant)	☐	Keloid scarring	☐	Any conditions not covered by insurance policy	☐
Cuts and abrasions	☐	Active inflammatory dermatoses (for example: psoriasis)	☐	Anxiety	☐
Bruises	☐	Current medication	☐	Diabetes	☐
Epilation	☐	Epilepsy	☐	History of scarring	☐
Intense pulsed light (IPL) or laser in the treatment area	☐	Recurrent Herpes Simplex	☐	Large moles	☐
Roaccutane/Isotretinoin use within 6 – 12 months	☐	Long term anti-inflammatory use	☐	Piercings	☐
Poor mental and emotional state	☐	Recent botulinum toxin injections or dermal fillers	☐	Recent dermabrasion or cosmetic skin peels	☐
Sensitive or excessively reactive skin types	☐	Supplements and herbal remedies	☐	Recent UV exposure	☐
Active suntan	☐	Artificial tan	☐	Blood donation	☐
MRI scan	☐				
Comments:					

Contra-indications that require medical referral– *(Select if/where appropriate):*		
Radiation treatment ☐	Current prescribed medications ☐	Chemotherapy ☐
Immune conditions ☐	Areas of skin or moles that have uneven asymmetry, ragged or blurred borders ☐	Areas of skin or moles that have uneven patchy colour or uneven diameter ☐
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 ☐	Peri-menopausal ☐	Menopausal ☐
Post menopause ☐		

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 prophylactic anti-viral is being taken:	Yes ☐	Yes ☐

Have you had any of the following within the last 14 days?					
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 ☐
If yes, please specify treatment details (to include treatment dates, frequency, results and client satisfaction with outcome):					

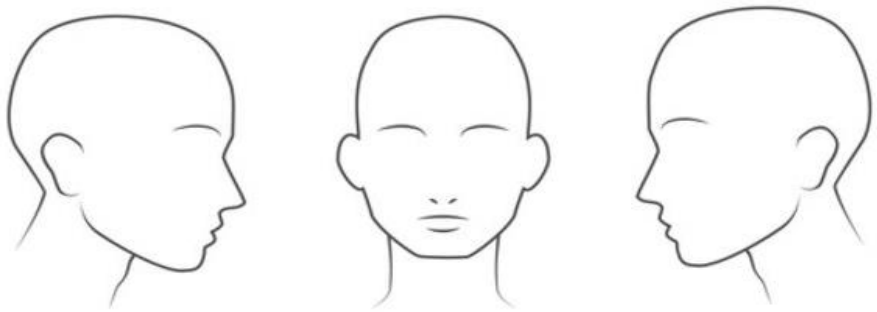
Do you use Retin A or any other prescription skin/scalp or hair care products?		
If yes, please specify details:	Yes ☐	No ☐
Have you taken/used Isotretinoin within the last 6-12 months?		
If yes, please specify details:	Yes ☐	No ☐

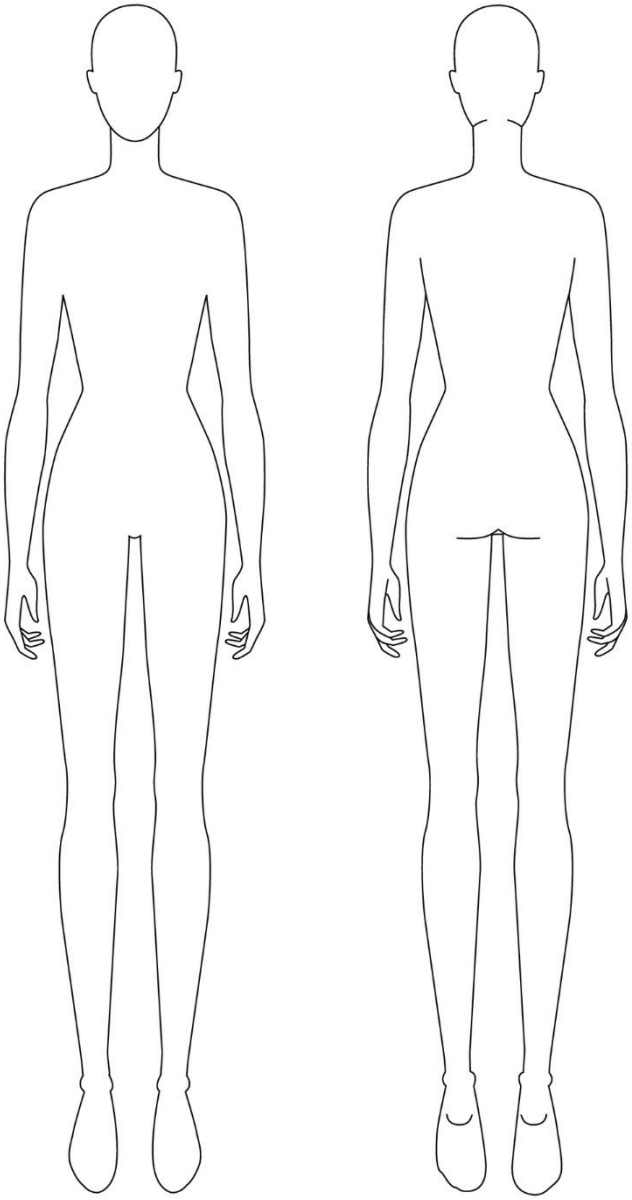
Do you use home care products containing any of the following?					
Exfoliating granules	☐	Glycolic Acid	☐	Lactic Acid	☐
Other Alpha Hydroxy Acids	☐	Vitamin A derivatives (Retinol)	☐	Salicylic Acid	☐
If yes, please specify skin reaction after use:					
What is your current daily skin/scalp/hair care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

Skin/scalp 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/Scalp characteristics/ conditions	Glogau photo damage ☐	Hyper pigmentation ☐	Hypo pigmentation ☐
	Sensitive ☐	Static wrinkles ☐	Dynamic wrinkles ☐
	Open pores ☐	Pigmentation ☐	Scarring ☐
	Vascular lesions ☐	Irregularities ☐	Itching/Pruritus ☐
	Tinea capitis ☐	Pediculosis capitis ☐	Seborrheic eczema/cradle cap ☐
	Psoriasis ☐	Scleroderma ☐	Graft versus host disease ☐
	Leishmaniasis ☐	Temporal arteritis ☐	Trauma ☐
	Alopecia ☐	Seborrheic dermatitis ☐	Trichotillomania ☐
	Other ☐		
Hair loss characteristics	Widow's peak ☐	High hairline ☐	Triangular hairline ☐
	Bell-shaped ☐	Receding or M shaped hairline ☐	
Scalp/skin colour			
Tones and undertones			
Level of sensitivity			
Thickness of scalp/skin			
Epidermal thickness			
Healing capacity			
Surface hydration levels			
Skin laxity			
Type of scarring			
Type of lesions/ irregularities			
Existing or remaining hair colour, thickness and follicle size			
Hair loss classification scale used if relevant			

Skin sensitivity patch test: (Documentary evidence of patch test to be included)	Date:		
	Area(s) tested:		
	Patch test reaction:	Positive ☐	Negative ☐
	Tactile test:	Positive ☐	Negative ☐
	Additional comments:		

Treatment objectives:	Improve appearance of natural hairline ☐	Define natural hairline ☐	Balance natural hairline ☐
	Simulation of follicles/shaved hair ☐	Simulation of hair strokes ☐	Scalp camouflage ☐
	Introduce skin colouring ☐	Partial head ☐	Full head ☐

Proposed treatment plan – (detail where appropriate)	



Pre-treatment photograph taken:	Yes ☐	No ☐	
Comments:			
Post template taken if applicable:	Yes ☐	No ☐	
Comments:			

Treatment details:			
Topical anaesthetic			
Needle/cartridge size, expiry date and batch number			
Pigment selection and batch number			
Skin/scalp reaction/ retention			
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:	

Pre-treatment consent and Treatment information

The scalp micropigmentation treatment is designed to replicate the appearance of natural hair follicles and shaven hair, or applied to camouflage scars on the scalp or areas of thinning hair or hair loss. During the treatment you may experience some mild to moderate discomfort, a sense of vibration, pressure or a feeling that the skin/scalp is being pricked. 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/scalp may feel tight and sore. You may also experience mild erythema (redness) for 2-3 days. Implanted colour usually appears darker initially and then lighter as it heals.

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 skin/scalp/hair care 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 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:

- Excessive discomfort
- Blistering
- Bruising
- Stinging
- Weeping
- Nausea
- Fainting
- Erythema (redness)
- Oedema
- Pain
- Anaphylaxis
- Crusting/scabbing
- Flaking
- Hives
- Lack of retention
- Colour fade
- Migration of pigment
- Hypertrophic or keloid scarring

_____ 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 and possible removal procedures 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, after template where applicable and after each treatment to monitor and document progress.
I hereby authorise _____ to take photographs of the area before, after template where applicable, 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. Avoid washing the area for at least 7 days
3. Avoid AHAs, BHAs and Retinoids in all future treatments as these can fade the pigment
4. Wash hands before touching treated area
5. To clean or if the area weeps bathe with clean warm water and mild antibacterial cleanser
6. Apply healing balm/cream 2-4 times a day with a clean cotton bud/pad to each area
7. Do not scratch, rub or pick the area or pull off scabs which will fall off naturally, if concerned contact your advanced aesthetic practitioner in the first instance
8. Avoid pets and unclean surfaces to reduce risk of infection
9. Avoid immediate vigorous exercise and other spa/beauty treatments
10. Avoid sun exposure, heat treatments, polluted atmospheres and topical preparations (except those recommended by the practitioner), wear a clean, soft head covering if needed to protect the area

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 scalp micropigmentation 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: _____