

Case Study Consultation Form

UBT475 – Perform hair growth reduction using Intense Pulsed Light systems

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 – 29 <input type="checkbox"/>	30 – 39 <input type="checkbox"/>	40 – 49 <input type="checkbox"/>	50 – 59 <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 treatment (absolute contra-indications) – (Select if/where appropriate):

Certain photosensitive medication (such as Amiodarone, Minocycline, St John's Wort) <input type="checkbox"/>	Directly over moles/birthmarks <input type="checkbox"/>	Permanent or semi-permanent make-up <input type="checkbox"/>
Gold medications <input type="checkbox"/>	Hair lighter than the skin colour <input type="checkbox"/>	History of or present use of melatonin <input type="checkbox"/>
History of skin cancer/malignant melanoma <input type="checkbox"/>	Haemophilia <input type="checkbox"/>	Diabetes/poorly controlled diabetes <input type="checkbox"/>
HIV, AIDS <input type="checkbox"/>	Hepatitis B or C <input type="checkbox"/>	Inappropriate hair colour <input type="checkbox"/>
Keloid scarring <input type="checkbox"/>	Autoimmune diseases <input type="checkbox"/>	Lupus <input type="checkbox"/>
Lymphatic system disorders <input type="checkbox"/>	Metal pins and plates <input type="checkbox"/>	Oral and topical medication for Photo-Dynamic Therapy <input type="checkbox"/>
Oral and topical steroids <input type="checkbox"/>	Angina <input type="checkbox"/>	Pacemaker/ defibrillator <input type="checkbox"/>
Vascular diseases <input type="checkbox"/>	Bleeding or clotting disorders <input type="checkbox"/>	Pigmentary disturbance (for example vitiligo, pigmented naevi) <input type="checkbox"/>
Porphyria <input type="checkbox"/>	Pregnancy <input type="checkbox"/>	Semi-permanent and permanent injectable filler products <input type="checkbox"/>
Suntanned skin <input type="checkbox"/>	White hair <input type="checkbox"/>	Grey hair <input type="checkbox"/>
Blonde hair <input type="checkbox"/>	Very fine hair <input type="checkbox"/>	

Comments:

Contra-indications that restrict treatment (relative contra-indications) – (Select if/where appropriate):		
Abrasions <input type="checkbox"/>	Acne <input type="checkbox"/>	Bruises <input type="checkbox"/>
Allergies <input type="checkbox"/>	Cuts <input type="checkbox"/>	Artificial tan <input type="checkbox"/>
Active tan /recent UV exposure <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Areas of undiagnosed pain <input type="checkbox"/>
Botulinum toxin <input type="checkbox"/>	Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) <input type="checkbox"/>	Chemical peels <input type="checkbox"/>
Clients taking anti-coagulant medication <input type="checkbox"/>	Clients sensitive to light (within the range of 500nm-900nm) <input type="checkbox"/>	Connective tissue disorders (such as scleroderma) <input type="checkbox"/>
Contagious or infectious diseases <input type="checkbox"/>	Drugs which cause skin thinning <input type="checkbox"/>	Depression <input type="checkbox"/>
Anxiety <input type="checkbox"/>	Eczema <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Fever <input type="checkbox"/>	Herpes simplex <input type="checkbox"/>	Herpes zoster <input type="checkbox"/>
Injectable fillers <input type="checkbox"/>	Loss of skin sensitivity <input type="checkbox"/>	Skin diseases <input type="checkbox"/>
Basal cell carcinoma (BCC) <input type="checkbox"/>	Squamous cell carcinoma (SSC) <input type="checkbox"/>	Poor mental and emotional state <input type="checkbox"/>
Pregnancy <input type="checkbox"/>	Breastfeeding <input type="checkbox"/>	Psoriasis <input type="checkbox"/>
Tattoos <input type="checkbox"/>	Under the influence of drugs or alcohol <input type="checkbox"/>	Undiagnosed swelling <input type="checkbox"/>
Urticaria <input type="checkbox"/>	Varicose veins <input type="checkbox"/>	Other <input type="checkbox"/>
Comments: 		

Contra-indications requiring medical permission:		
Active acne <input type="checkbox"/>	Acute rheumatism <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Any condition already being treated by a General Practitioner/Dermatologist <input type="checkbox"/>	Nervous psychotic conditions <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Bell's Palsy <input type="checkbox"/>	Recent operations <input type="checkbox"/>	Medical oedema <input type="checkbox"/>
Inflamed/trapped/pinched nerve <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Other <input type="checkbox"/>

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:
Additional comments:			
Do you smoke or vape?			
If yes, how many per day?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you drink alcohol?			
If yes, how many units per week?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you trying to conceive, pregnant or lactating?			
If yes, please specify:		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"/>	
Additional details including date of last menstrual period if relevant:			
Do you have any allergies?			
If yes, please provide details:		Yes <input type="checkbox"/>	No <input type="checkbox"/>
What is your level of sun exposure?			
Please specify details:			

Are you currently sun/wind burnt?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wear a sun protectant?					
If yes, please specify SPF/frequency of application:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from Herpes simplex?					
If yes, please specify where outbreaks occur/frequency and likely triggers:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had any of the following within the last 14 days?					
Neuromodulation injections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Light based therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dermal fillers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	LASER	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depilatory treatments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Microdermabrasion	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Electrolysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Skin needling	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Facial surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Skin peeling	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IPL	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Have you taken/used Isotretinoin or any other skin medication within the last 6-12 months?					
If yes, please specify details:				Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you use or have you ever used home care products containing any of the following?

Exfoliating granules

☐

Glycolic Acid

☐

Lactic Acid

☐

Salicylic Acid

☐

Vitamin A derivatives (Retinol)

☐

Other Acid based products

☐

If yes, please specify frequency, skin reaction after use:

What is your current daily skincare regime, including product details?

Morning:

Evening:

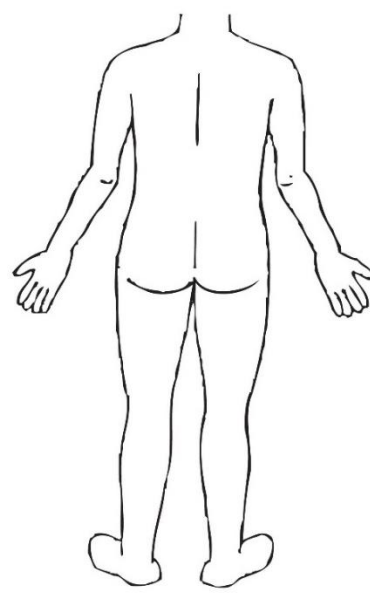
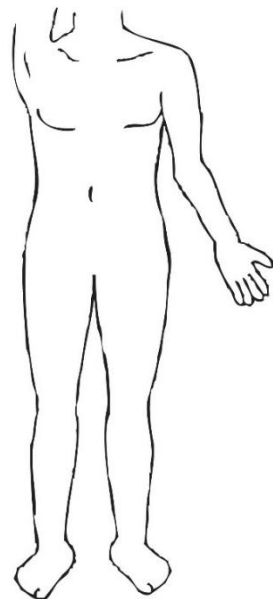
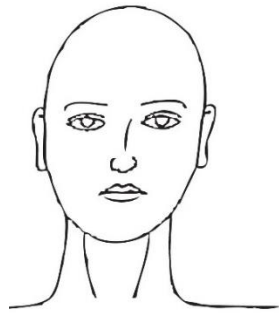
What specific areas of concern?

What are your expectations of this treatment?

Skin assessment:						
Skin type and classification	Balanced	<input type="checkbox"/>	Combination	<input type="checkbox"/>	Dry	<input type="checkbox"/>
	Oily	<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"/>
	Glogau photo damage	<input type="checkbox"/>	Lancer Scale	<input type="checkbox"/>		
Additional comments:						
Skin condition	Sensitive	<input type="checkbox"/>	Dehydrated	<input type="checkbox"/>	Mature	<input type="checkbox"/>
	Broken capillaries	<input type="checkbox"/>	Papules	<input type="checkbox"/>	Open pores	<input type="checkbox"/>
	Dark circles	<input type="checkbox"/>	Pigmentation	<input type="checkbox"/>	Scarring	<input type="checkbox"/>
	Erythema	<input type="checkbox"/>	Skin lesions	<input type="checkbox"/>	Moles	<input type="checkbox"/>
Skin hydration levels						
Skin collagen levels						
Skin density						
Epidermal thickness						
Skin healing ability						
	Brown pigmentation	<input type="checkbox"/>	Pink/fades to white	<input type="checkbox"/>	Hypertrophic/keloid	<input type="checkbox"/>
	Additional comments:					
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"/>
	Thermal test:		Positive	<input type="checkbox"/>	Negative	<input type="checkbox"/>
	Tactile test:		Positive	<input type="checkbox"/>	Negative	<input type="checkbox"/>

	<i>Additional comments:</i>		
Hair types	Fine hair <input type="checkbox"/>	Coarse hair <input type="checkbox"/>	Dark pigmented hair <input type="checkbox"/>
	Medium pigmented hair <input type="checkbox"/>		
Treatment objectives	Management of hair growth <input type="checkbox"/>	Reduction of hair growth <input type="checkbox"/>	

Area(s) to be treated
(detail where appropriate)



Colour of hair

Causes of hair growth

Hair growth pattern/density

Site of hair growth

Pre-treatment
visual media
images taken

Yes

☐

No

☐

Comments:

Treatment parameters/details – (including client reaction to treatment and **ALL treatment parameters):**

(Wavelength, fluence, pulse duration/width, delay, repetition, spot size:)

Duration of application			
Reaction levels			
Areas requiring modification			
Skin reaction to treatment			
Post-treatment visual media taken	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Client feedback			
Post-care/Home care advice given			

Comments:

Pre-treatment consent and Treatment information

The intense pulsed light treatment is designed to reduce hair growth. During the treatment you may experience a mild stinging or a sensation similar to a rubber band snapping and there may be a smell of burning hair. This will fade following treatment, but you should tell your advanced aesthetic practitioner about the sensations you experience during treatment.

Immediately following treatment, you may experience mild erythema (redness) for 1-2 days

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 3 days after treatment.

_____ I agree to follow the advice of my advanced aesthetic practitioner regarding the use of skin or body products 3-5 days prior to treatment.

_____ I agree not to receive any of the following on the treatment area 1 week prior to treatment – Neuromodulation injections/injectable dermal fillers or needling treatments.

_____ I agree not to receive any of the following on the treatment area 30 days prior to treatment – bleaching, electrolysis, depilation, waxing, use of depilatory creams, sunbathing/use of sunbeds

_____ I agree to avoid the use of self-tanning products 2 weeks prior to treatment

_____ I agree to avoid the use of any prescribed topical 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 prior to treatment.

_____ I agree to avoid direct sun exposure.

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

_____ I agree to avoid any 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:

- | | | |
|------------------------------------|-------------------------------------|--------------------------------|
| • Inflammation | • Hypo-pigmentation | • Excessive prolonged erythema |
| • Itching | • Hyper-pigmentation | |
| • Blistering | • Erythema | |
| • Bruising | • Sensitivity | |
| • Spots of bleeding under the skin | • Infection | |
| • Swelling | • Cellulitis | |
| | • Unexplained increased hair growth | |

_____ I understand that thermal/tactile tests must be performed to ascertain my levels of sensitivity.

_____ I understand that there is a possibility of unexplained hair growth in the area.

_____ 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 inform the practitioner performing the treatment of any adverse effects.

_____ My advanced aesthetic practitioner has provided treatment information and answered all the questions I have concerning this treatment.

_____ I fully understand all 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. Avoid additional heat treatment such as saunas, steam rooms, sun beds for 48 hours as excess heat can lead to discomfort, inflammation and irritation
3. Immediately following treatment, it is essential that you apply a broad-spectrum physical sunscreen (minimum SPF30). This must be reapplied according to manufacturer's instructions
4. Avoid direct sun exposure for 48 hours following treatment
5. Avoid strenuous/excessive exercise for 24 hours to prevent overheating/increased blood circulation
6. Increase water intake to at least 2 litres per day
7. Avoid the use of glycolic acid, retinol, AHA/BHA products for at least 24-48 hours
8. Use post-treatment products as instructed by your advanced aesthetic practitioner
9. Your advanced aesthetic practitioner will advise you of ongoing treatment recommendations and suitable treatments which may be used in conjunction with intense pulsed light 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 skin sensitivity/patch test(s) 24-48 prior to intense pulsed light 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	<p><i>Treatment evaluation and reflective practice should include, but is not limited to:</i></p> <ul style="list-style-type: none">• Indications for the treatment of hair growth reduction using intense pulsed light systems• 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
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