Case Study Consultation Form

UBT476 – Perform hair growth reduction using LASER systems

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

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

Personal details:						
Age group:	Under 20 ☐	20 – 29 ☐	30 – 39 ☐	40 – 49 ☐	50 – 59 ☐	60+ ☐
Occupation:						
Lifestyle:	Active ☐			Sedentary ☐		
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) ☐	Directly over moles/birthmarks ☐	Permanent or semi-permanent make-up ☐
Gold medications ☐	Hair lighter than the skin colour ☐	History of or present use of melatonin ☐
History of skin cancer/malignant melanoma ☐	Haemophilia ☐	Diabetes/poorly controlled diabetes ☐
HIV, AIDS ☐	Hepatitis B or C ☐	Inappropriate hair colour ☐
Keloid scarring ☐	Autoimmune diseases ☐	Lupus ☐
Lymphatic system disorders ☐	Metal pins and plates ☐	Oral and topical medication for Photo-Dynamic Therapy ☐
Oral and topical steroids ☐	Angina ☐	Pacemaker/ defibrillator ☐
Vascular diseases ☐	Bleeding or clotting disorders ☐	Pigmentary disturbance (for example vitiligo, pigmented naevi) ☐
Porphyria ☐	Pregnancy ☐	Semi-permanent and permanent injectable filler products ☐
Suntanned skin ☐	White hair ☐	Grey hair ☐
Blonde hair ☐	Very fine hair ☐	
Comments:		

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

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

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 ☐	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 ☐
Additional details including date of last menstrual period if relevant:		

Do you have any allergies?		
If yes, please provide details:	Yes ☐	No ☐

What is your level of sun exposure?
Please specify details:

Are you currently sun/wind burnt?	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 ☐

Have you had any of the following within the last 14 days?					
Neuromodulation injections	Yes ☐	No ☐	Light based therapy	Yes ☐	No ☐
Dermal fillers	Yes ☐	No ☐	LASER	Yes ☐	No ☐
Depilatory treatments	Yes ☐	No ☐	Microdermabrasion	Yes ☐	No ☐
Electrolysis	Yes ☐	No ☐	Skin needling	Yes ☐	No ☐
Facial surgery	Yes ☐	No ☐	Skin peeling	Yes ☐	No ☐
IPL	Yes ☐	No ☐	Other	Yes ☐	No ☐
If yes, please specify treatment details (to include treatment dates, frequency, results and client satisfaction with outcome):					

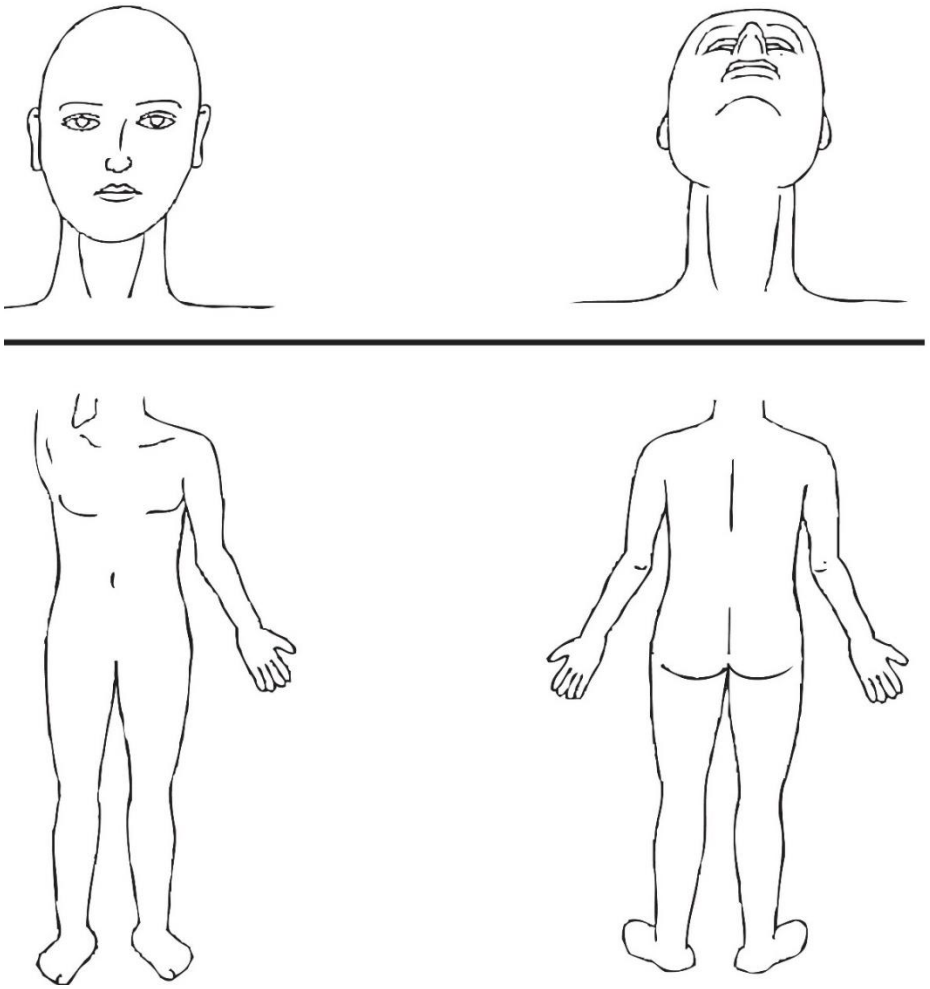
Do you use Retin A or any other prescription skincare products?		
If yes, please specify details:	Yes ☐	No ☐
Have you taken/used Isotretinoin or any other skin medication within the last 6-12 months?		
If yes, please specify details:	Yes ☐	No ☐

Do you use or have you ever used home care products containing any of the following?		
Exfoliating granules ☐	Glycolic Acid ☐	Lactic Acid ☐
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 ☐	Combination ☐	Dry ☐
	Oily ☐		
	Fitzpatrick scale I ☐	Fitzpatrick scale II ☐	Fitzpatrick scale III ☐
	Fitzpatrick scale IV ☐	Fitzpatrick scale V ☐	Fitzpatrick scale VI ☐
	Glogau photo damage ☐	Lancer Scale ☐	
Skin condition	Sensitive ☐	Dehydrated ☐	Mature ☐
	Broken capillaries ☐	Papules ☐	Open pores ☐
	Dark circles ☐	Pigmentation ☐	Scarring ☐
	Erythema ☐	Skin lesions ☐	Moles ☐
Skin hydration levels			
Skin collagen levels			
Skin density			
Epidermal thickness			
Skin healing capacity	Brown pigmentation ☐	Pink/fades to white ☐	Hypertrophic/keloid ☐
	Additional comments:		

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

Hair types			
	Fine hair ☐	Coarse hair ☐	Dark pigmented hair ☐
	Medium pigmented hair ☐		

Treatment objectives	Management of hair growth ☐	Reduction of hair growth ☐	
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 ☐	No ☐	
Client feedback			
Post-care/Home care advice given			
Comments:			

Pre-treatment consent and Treatment information

The LASER 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 tropical 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 filers 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:

- Hyperaemia
- Itching
- Oozing and crusting
- Scarring
- Blistering
- Bruising
- Burns
- Spots of bleeding under the skin
- Swelling
- Frazzling of hair
- Smell of burning hair
- Urticaria
- Hypo-pigmentation
- Hyper-pigmentation
- Excessive discomfort
- Skin greying or whitening
- Erythema
- Sensitivity
- Dizziness
- Infection
- Cellulitis
- Unexplained increased hair growth
- Excessive prolonged erythema
- Excessive perifollicular oedema
- Unexplained increased hair growth/paradoxical LASER induced 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 increased 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 LASER 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 LASER 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:* • Indications for the treatment of hair growth reduction using LASER 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