Surname: _____

First Name: _____

Treatment area (s)(Please state)

_____

Gentlelase/ GentleYAG / GentleMax

Patient Consultation Form

Photograph Ref _____

Photographs taken date _____

PERSONAL INFORMATION

Surname _____ **First Name** _____

Address

_____

_____ **Postcode** _____

Tel No: _____ **Date of Birth** _____

Mobile Number _____ **Email** _____

Profession:

_____

How did you hear about us _____

Expectations and Motivations

_____

_____

LIFESTYLE

Skin Care Regimen (explain in detail type of products) _____

_____

Skin Type _____

How have you removed the hairs in the past ? _____

How Frequently_____

Do you have any known hormone inbalances ?

_____

Skin Type `(Fitzpatrick)
How well do you tan (Do you burn _____

How well do you hold a tan (how long does it last) _____

Do your parents have darker skin or lighter than you _____

Career/Work /hours per week _____

Relaxation Time/ hours per week _____

MEDICAL ASSESSMENT

Are you taking any medication _____
In particular photosensitizing medications e.g st Johns Wort, Roaccutane)

Do you have any allergies _____

Pregnancy (previous and current) _____

Are you currently receiving medical treatment _____

Have you had any recent operations/scar tissue_____

Do you have any tumors, abnormal swelling or lymph oedema _____

Do you have any heart/cardiac disorders _____

Do you have Thrombosis/Phlebitis (blood clots) _____

Do you have a Pacemaker or internal metal pins _____

Is there a personal/family history of skin cancer _____

Do you have epilepsy _____

Do you have Diabetes (Give details)_____

Very recent exposure to UV light _____
Including sun beds

Recent use of self tanning/ skin colouring products_____

History of Keloid (Raised) scarring _____

Fragile or exceptionally dry skin _____

Do you suffer from Herpes Simplex 2 (cold sores) _____

Have you recently had Botox/Collagen/injectables _____

Do you take any form of contraception/hormonal substitutive _____

Do you have a tattoo/semi permanent make up in the area _____

Do you have any of the following: Thyroid problem _____

Do you have any skin disorders ? _____
Psoriasis Dermatitis or Vitiligo, Pigmentation, eczema (in treatment area)

Date completed _____ Signed _____

[Note If Highlighted in Red needs doctors permission in some cases only if in treatment area]

Treatment Consent Form Patient Copy

I confirm that I have received a full Consultation with regards to the proposed Laser /IPL hair removal treatment and would agree that is has been explained to me fully. I am aware of the possible side affects and agree to follow both the pre and post care to minimise the risk of any adverse reaction.

I agree to advice the clinic/salon of any changes in personal medical circumstances.

I understand that after treatment, there will be heat in the area and may be some redness. In rare cases oedema and blistering can occur. This is a normal side effect of treatment and will settle within days. Instructions have been given regarding aftercare and advice and I agree to follow these instructions and to inform the clinic of any condition that causes concern immediately.

I understand that I will require more than one treatment to achieve the desired results. This has been fully explained to me and I am aware the results of the treatment may vary.

I understand the need to advise the staff of any changes to medication or any sun exposure, sun bed use or tanning products used between treatments.

I have been advised to shave hair in the weeks between treatment and that waxing and plucking hairs will result in a prolonged treatment plan

I hereby certify that I have been fully informed of the nature of the procedure, expected outcome and possible complications. I understand that there can be no guarantee or assurance as to the final result that may be obtained.

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion. I am aware that my condition is primarily of cosmetic concern and that the decision to proceed is based solely on my express wish to do so.

I have been given the opportunity to ask questions and hereby certify that I have read and fully understand the contents of this consent form.

_____ Patient's Signature _____
Date

_____ Practitioners Signature _____
Date

Treatment Consent Form Clinic copy

I confirm that I have received a full Consultation with regards to the proposed laser Hair removal treatment and would agree that is has been explained to me fully. I am aware of the possible side affects and agree to follow both the pre and post care to minimise the risk of any adverse reaction.

I agree to advice the clinic/salon of any changes in personal medical circumstances.

I understand that after treatment, there will be heat in the area and may be some redness. In rare cases oedema and blistering can occur. This is a normal side effect of treatment and will settle within days. Instructions have been given regarding aftercare and advice and I agree to follow these instructions and to inform the clinic of any condition that causes concern immediately.

I understand that I will require more than one treatment to achieve the desired results. This has been fully explained to me and I am aware the results of the treatment may vary.

I understand the need to advise the staff of any changes to medication or any sun exposure, sunbed use or tanning products used between treatments.

I have been advised to shave hair in the weeks between treatment and that waxing and plucking hairs will result in a prolonged treatment plan

I hereby certify that I have been fully informed of the nature of the procedure, expected outcome and possible complications. I understand that there can be no guarantee or assurance as to the final result that may be obtained. I am able to consent for myself and I am over the age of 18 years (or I am able to give consent on behalf of the patient)

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion. I am aware that my condition is primarily of cosmetic concern and that the decision to proceed is based solely on my express wish to do so.

I have been given the opportunity to ask questions and hereby certify that I have read and fully understand the contents of this consent form.

_____ Patient's Signature _____
Date

_____ Practitioners Signature _____
Date

Consultation Record

Date _____

Practitioner _____

Medical Questionnaire completed and checked □

Consent signed □

Pre and Post instructions given □

Photographs taken □

Payment advised and agreed □

Test patch date □

Notes

_____

_____

_____

Payment Details

Single Payment Plan Course Payment Plan

Single Payment	Date	Initialed		Course Payment	Date	Amt Trts	Initialed

I agree to the above type of payment plan Option
A Single Payment □ B Course Payment □

A The amount I agree to pay per Treatment is _____ Date _____

B The amount I agree to pay for a Course of Treatment is _____Date _____

Signature of Patient _____ Date _____

Signature of Operator _____Date _____

________Insert Clinic Details __________________________________

Treatment Notes

Patient Name ___________________________________

Date	Treatment Notes	Time	Practitioner

Please sign the section below each time a treatment is carried out to ensure no changes.

Statement

I agree that I have not changed any medications/taken additional medications prior to this treatment
I have not been exposed (in the area to be treated) to the sun or sunbeds for prolonged periods without suitable protection.
I have not used any tanning or colouring products on my skin in the last two weeks
I have not bleached, plucked or removed hair with depilatory cream.
I have not used any harsh chemicals/peels in the area to be treated (e.g. Retinol)

DATE	Name and patient No	Signed	Therapist

	Note any changes		

Aftercare instructions

BEFORE TREATMENT

1. Avoid the sun 4-6 weeks before and after treatment.
2. You MUST avoid bleaching, plucking or waxing hair for 6 weeks prior to treatment.
3. Do not use Depilatory creams 1 week prior to treatment.
4. If have had a history of cold sores, zovirax may be used prior to treatment and continued one week after treatment.
5. TANNED SKIN CANNOT BE TREATED! If treated, you may get hypopigmentation (white spots) and this may not clear for 2-3 months or more. Also, the use of tanning cream must be discontinued two week before treatment.
6. Please shave the area the day before or morning before the treatments

DURING TREATMENT

1. The skin is cleaned
2. When treating the upper lip, the teeth may be protected with gauze. The gauze also serves to support the lip during treatment, allowing a surface to push against.
3. Skin colour can compete as a target for the laser wavelength with melanin in the hair. The cooling tip will be used with the laser to minimize skin damage.
4. Safety considerations are important during the laser procedure..Protective eyewear will be worn by the client and the operator during the procedure.

AFTERCARE

1. Immediately after treatment, there may be redness and swelling at the treatment area, this may feel like mild sunburn
2. The application of iced water during the first few hours after treatment will reduce any discomfort.
3. The application of aloe vera gel can continue at home
4. Makeup may be used immediately after the treatment unless there is epidermal blistering.
5. Avoid sun exposure to reduce the chance of hyperpigmentation or darker pigmentation. Use sunscreen SPF 30 or greater at all times throughout the course of treatment.
6. Avoid picking or scratching the treated skin. Do not use any other hair removal treatment methods (waxing, electrolysis or tweezing) that will disturb the hair follicle at the treatment area for 4-6 weeks after treatment. Shaving or depilatories may be used.
7. Hair regrowth occurs at different rates on different areas of the body. New hair growth will not occur for AT LEAST three weeks after treatment.
8. Anywhere from 5-19 days after the treatment, shedding of the surface hair may occur and this appears as new hair growth. This is NOT new hair growth. You can clean and remove the hair by washing or wiping the area with a wet cloth or Loofa sponge.
9. After the underarms are treated, use a powder, instead of deodorant, for 24 hours after the treatment to reduce skin irritation.
10. Avoid hot baths and heat treatments and treat the skin gently, as if you had sunburn, for the first 24 hours.
11. ANY QUESTIONS OR WORRIES YOU MAY HAVE PLEASE CALL THE CLINIC ON