Client Medical Consent Form

Tattoo Removal	☐	Cavitation Treatment	☐	Radio Frequency Treatment	☐
IPL Hair Removal	☐	Laser Red Vein Treatment	☐	Photo Rejuvenation	☐
Laser Hair removal	☐	Pigmentation	☐	Skin Resurfacing	☐

Title (Mr/Mrs/Ms/Miss)	GP Name & Surgery:	
Client Name	GP Contact No:	
Address	Tel Home:	
	Tel Work:	
	Tel Mobile	
	E-mail Address	
Postcode:	Age:	Gender:

How did you hear about us?

Are you currently or have you ever suffered from any of the following			
	Yes	**No**	Comment
Epilepsy			
Urine infection			
Diabetes			
Cancer (Skin or other)			
Medical oedema			
HRT (Hormone replacement therapy)			
Contraceptive			
Any Kidney problems or issues			
Auto immune disease			
Currently pregnant			
Gastric ulcers			
Any form of infection, fever or disease			
Cardio vascular conditions			
Regular antibiotics/medication taken			
Vitiligo (excess pigmentation)			
Keloid Scarring			
Polycystic Ovarian Syndrome			
Pacemaker			
Hepatitis or Aids			
Any Skin Conditions			
Hypertension			
Lupus			
Recurring Herpes Simplex			
Haemophilia or other blood disorders			
Do you use sun beds			
Do you use or have chemical peels			

Thyroid problems			

Any metal pins or plates			
Loss of skin sensation			
Muscular/skeletal problems			Back aches/pain/stiff joints/headaches
Digestive problems			Constipation/Bloating/Liver/Gall bladder/Stomach
Circulation problems			Heart/Blood pressure/Fluid retention/Varicose veins/DVT
Gynaecological problems or issues			Irregular periods/PMT/Menopause
Nervous system			Migraine/Tension/Stress/Depression
Immune system			Prone to infections/Sore throats/Colds/Chest/Sinuses
Allergies			
Any condition already being treated by a practitioner:			
Under the influence of recreational drugs or alcohol:			

List ALL medication that you are currently taking or have taken in the last twelve months including non-prescriptions

Please list any operations/Fractures/Scars/Localised swelling etc ….

Patient Consent

I accept to undergo a ***Hair Removal/Vein Removal/Acne Clearance/Photo rejuvenation/Skin Resurfacing*** treatment or course. I have been informed about contra-indications and possible complications and any questions I have regardingthe treatment have been answered to my satisfaction. I can confirm that I am not pregnant and that the information I have provided is correct. I understand that the result of the treatment is notguaranteed and results may not be obtained. I agree to adhere to all safety precautions and regulations during the treatment. I understand that I am under obligation to inform the clinic of any changes in my health or medications prior to each treatment.

Patient Signature ……. **Date** ……..

Therapist Signature…….. **Date** ……

Please attached this record sheet to client consultation card and Fitzpatrick scale once first treatment is completed

Laser Treatment Record Sheet

DATE	MACHINE NAME	EYE WEAR CODE	TREATMENT CODE	TREATMENT AREA	TREATMENT NO	SKIN TYPE	FLUENCE (Jcm2)	STACKS	BURSTS (Jcm2)	PASSES	PHOTO	LASER SPECIALIST (Print Name)
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	

Record Key Code

Treatment Code:

PT - Patch Test
HR – Hair Removal
RVR – Red Vein Removal
PR – Photo Rejuvenation
AC – Acne Clearance
PR – Pigmentation Removal

Safety Eye Wear Code:

Red Tag – Laser Goggles
Green Tag – IPL Goggles
White Tag – Client Goggles
EP – Eye Pads

Laser Treatment Record Sheet

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DATE	MACHINE NAME	EYEWEAR CODE	TREATMENT CODE	TREATMENT AREA	TREATMENT NO	SKIN TYPE	FLUENCE (j/cm2)	GRID SIZE	KJS	TOTAL SHOT COUNT	PHOTO TAKEN	LASER/IPL SPECIALIST (Print Name)
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	
											Y N	

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