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| C O L L A G E N L I F TTMP R O F E S S I O N A L |

# CONSULTATION FORM

|  |  |
| --- | --- |
|  **Therapist/Practitioner’s Name: Ceri Parker**  | **Date:** |
| **Client Details (delete Yes or No or as applicable)** |  |
|  Client Name:  |   |   | Address:  |
|  Date of Birth:  |   |  |
|  Gender:  | Male  | Female  | Postcode:  |
|  Occupation:  |   |  | Tel. No:  |
|  Over 18?  | Yes  | No | I consent to my data being stored in the Collagen Lift ™ machine. If not, an anonymous reference number will be allocated. Ref: .............................. |
|  Email: |   |  |  |

## Health and Lifestyle

|  |  |  |
| --- | --- | --- |
| **Major Contraindications****- Do not proceed (delete Yes or No as applicable)** |  | **Minor Contraindications****- Proceed avoiding affected areas** **(delete Yes or No as applicable)** |
| Kidney/Liver disease | Yes | No | Psoriasis or eczema  | Yes  | No  |
| Heart conditions (Pacemaker)  | Yes | No | Areas of sensory impairment  | Yes  | No |
| Auto-immune diseases  | Yes | No | Areas of very dry or fragile skin  | Yes  | No |
| Diabetes  | Yes | No | Herpes (Shingles/cold sores)  | Yes  | No |
| Immuno-suppressed individuals  | Yes | No | Bruises, abrasions or wounds  | Yes  | No |
| Chronic respiratory failure  | Yes | No | Active acne  | Yes  | No |
| Cerebral palsy  | Yes | No | Moles or skin tags  | Yes  | No |
| Inflammation or infection  | Yes | No | Metal pins/Plates/Implants  | Yes  | No |
| Abnormal swelling/Oedema  | Yes | No | Dental implants, braces, caps, metal fillings - For facials, please circle all that apply | Yes  | No |
| History of keloid scarring or abnormal wound healing | Yes | No |
| Inability to communicate | Yes | No |  |  |  |
| Connected to vital signs monitoring  | Yes | No | Any areas of surgical, invasive or ablative procedures in the treatment area before complete healing | Yes  | No |
| Benign or malignant tumours  | Yes | No |
| Arteriosclerosis obliterans  | Yes | No |
| **- Follow the advice given to proceed** | Any other conditions not listed? Yes NoIf yes please list:If you have answered yes to any contraindications, please give full details: |
| Varicose Veins | Yes | No |
| *If on the body; just avoid body treatments*Pregnancy *Must wait until after 6 week check up* | Yes | No |
| Cancer (Radiation/Chemotherapy) Especially skin cancer, pre-malignant moles in the treatment area*Must wait until in remission for 6 months* |

## Medication (delete Yes or No as applicable)

To ensure that you have no adverse reaction to Collagen Lift ™ treatments it is important for us to know if you are taking any medication. We may need to ask you to obtain Doctor’s consent before we can proceed with treatment.

|  |  |  |  |
| --- | --- | --- | --- |
|  Are you taking any medication/recreational drugs?  | Yes  | No  | *It is important that you are able to feel the heat from the treatment fully, and be able and aware of how to look after skin post treatment.* |
|  Are you currently, or have you used, Roaccutane, Isotretinoins or Retin A in the last 6 months?  | Yes   | No  | *If yes, wait 6 months after medication stops* |
|   If yes to any of the above please list fully below: |  |  |

## General Information (delete Yes or No or responses as applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| Have you had any chemical peels in the last 4 weeks? e.g., AHA’s or dermabrasion | Yes  |  No   |  If > 20% peel or dermabrasion wait 4 weeks  If < 20% peel or microdermabrasion wait 1 week |
| Have you had any injectable fillers in the last 6 months? e.g., collagen, restylane or Botox | Yes  |  No  |  If yes, wait 6 months before treatment  For Botox, wait 1 month before treatment |
| Do you suffer with any acute or chronic skin conditions in the treatment area? | Yes  |  No  |  If yes, avoid the area during treatment |
| Do you take any form of exercise?  | Yes  |  No  |  If yes, wait 24 hours after treatment |
| Do you smoke?  | Yes  | No  | If yes - High/Mod/Low | ***Smoking and drinking can compromise collagen production post treatment*** |
| Do you drink alcohol?  | Yes  | No  | If yes - High/Mod/Low |

Before commencing treatment it is important for us to have as much information as possible to ensure that you do not have an adverse reaction to Collagen Lift ™ Treatment. We therefore ask you to advise us immediately, and prior to any treatment, if there are any changes to the above information.

## Proposed areas of concern(s) for treatment with Collagen Lift ™ (delete items not applicable)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Wrinkles | Skin laxity | Acne scarring | Cellulite | Scars | Stretchmarks |

**Areas to be treated: (add a ‘X’ in area(s) required)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Around eyes  |  | Abdomen |  | Lower legs |  |
| Jowls |  | Hips |  | Thighs |  |
| Neck |  | Upper arms |  | Other areas: |
| Decollete |  | Full arms |  |
| Full face |  | Buttocks |  |

## Treatment programme (Practitioner to complete ahead of Client signature)

|  |  |  |  |
| --- | --- | --- | --- |
|  Patch test prior to treatment (skin test) | 1.  | 2. |  |
|  Post care recommendations: (  | Given in writing as part of induction  |  Yes  |  No |
|  |
|  Treatment course/Schedule recommended: |
|  Do you have any questions regarding the treatment procedure?  |
|  Additional notes (Practitioner) |
|  I certify that all of the statements and information given are true and correct and I understand and accept all terms and conditions.  **Client signature:**  **Date:** |

## Consent form By signing the Consent form below, you agree with the following statements

I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason

I have been fully informed about the possible side effects of the treatment including: skin redness (erythema) and warmth. Although these side effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

I understand that not everyone is a successful candidate for this treatment and results may vary

I confirm that I have read and understood all of the information and will undergo the treatment out of my own free will

I believe that I have adequate knowledge upon which to base an informed consent

I affirm that all information provided by me is correct to the best of my knowledge

I authorise before, during and after the procedure(s) the taking of photographs to be part of my patient profile. Confidentiality will be maintained.

I agree to adhere to all post treatment advice and agree to follow these guidelines at all times during the treatment programme

I agree that no refunds will be given for treatments received. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  **Client signature**  |  |  |  |  |  |  | **Date** |
| **Practitioner signature**  |  |  |  |  |  |  | **Date** |