®

SKIN TECH
Advanced Skin Technologies

PATIENT TREATMENT RECORD

Patient Name: _____ Date Of Birth: _____

Address: _____
_____
_____

Telephone No:_____

Email: _____

G.P's Name: _____

Address: _____
_____
_____

Telephone No:_____

Next of Kin Name: _____
(Relationship to the patient)
Address: _____
_____
_____

Telephone No. _____

List of previous or current cosmetic procedures (surgical and non-surgical):

Please describe you skin regime:

List any cosmetic procedures you may be interested in for future consideration:

Other notes:

Euromedical Systems Ltd
0845 130 4949

CONSENT FORM

Patient surname_____ First Names_____

Sex: Male/Female D.O.B____/____/_____

Clinician's Notes

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form

I confirm that I have explained the treatment, and such appropriate options as are available and the type of anesthetic, if any (general/regional/sedation) proposed, to the patient in terms which in my judgment are suited to the understanding of the patient and/or to one of the parent of guardians of the patient. I have confirmed that the patient is satisfied with this explanation.

Signature_____ Date_____ Name of clinician_____

Patient's Notes

Your Skin Tech clinician is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions or ask for any further information you require. You can refuse the treatment if you wish. You may ask for a relative or friend, or member of staff to be present at the consultation or treatment session. As part of their commitment to providing the highest possible quality of treatment, skin tech insists on thorough and continued training for all their clinicians. Your treatment may provide an important opportunity for such training, where necessary, under the careful supervision of a senior clinician. However, if you wish, you may refuse any involvement in a formal training program. Without this adversely affecting the quality of care and treatment.

Patient/Parent/Guardian

Please read this form and the notes very carefully, if there is anything that you do not understand about the explanation, or if you want more information, please ask the clinician.

Please check that all information on the form is correct. If you feel happy with all the explanations given please sign the form.

I am the patient/Parent/Guardian (delete as necessary)

I agree:

- To the action proposed, which has been explained to me by the clinician named on this form and have received relevant information and an advice sheet.
- To the use of a type of anesthetic, if needed to perform the procedure of which, I have been informed.
- To photographs being taken during the course of the treatment and to their use by Skin Tech for educational purposes if so required.
- I understand that a named Skin Tech clinician of my choice will provide the treatment.
- That any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- That whilst the treatment undertaken by a Skin Tech trained clinician is effective in the majority of patients treated, a small percentage of patients may fail to respond and the outcome of the treatment cannot be guaranteed.

I have read and understand the information presented for my treatment and I have answered all questions accurately. I agree to follow the treatment program for this procedure and return to the clinic for a review appointment on completion of my treatment.

Signature_____ Date_____ Print name_____

Address (if not the patient)_____

PATIENT MEDICAL HISTORY

Patient Name:…… Date:……..

1. Have you had any previous laser/skin peels? **Yes/No**

If yes, please give details:……

2. Current condition requiring treatment:……..

3. Are you attending or receiving treatment from a doctor or specialist? **Yes/No**

If yes, please give details: ……..……

4. Are you taking any medication, herbal remedies or any other drugs? **Yes/No**

If yes, please give details:..……

5. Are you allergic to any medicines, antibiotics, foods or other substances? **Yes/No**

If yes, please give details:..

6. Have you suffered from or had any of the following illnesses?

a. Psychiatric Illness/Depression	**Yes/No**
b. Heart Problems	**Yes/No**
c. Jaundice/Hepatitis	**Yes/No**
d. Epilepsy/Blackouts	**Yes/No**
e.Melasma (pigmentary change of the face)	**Yes/No**
f.Diabetes	**Yes/No**
g.Keloids	**Yes/No**
h.Blood disorders	**Yes/No**
i.Moles (Melanoacytic, Naeu/Melanoma)	**Yes/No**
j.Recent scar tissue (6 months)	**Yes/No**
k.Sunburn	**Yes/No**
l.Bruises	**Yes/No**
m.Cuts/abrasions	**Yes/No**
n.Excema	**Yes/No**
o.Psoriasis	**Yes/No**
p.Acne	**Yes/No**
q.Skin disorders/diseases (Barlenal,Fungal,Viral)	**Yes/No**
r.Albinism/Vitiligo	**Yes/No**
s.Port wine stains/ Strawberry Birthmarks	**Yes/No**
t.Pigmented birthmarks ie; Café a Laite	**Yes/No**
u.HIV	**Yes/No**
w.Unidentified Oedema	**Yes/No**
x.Unidentified lumps	**Yes/No**
y.Cold sores	**Yes/No**

7a. Are you pregnant?	**Yes/No**
b. Are you breast feeding	**Yes/No**

8. Have you had any form of cosmetic treatment e.g. Rhinoplasty, Blepharoplasty, Collagen injections, face lifts or aesthetic dental work? **Yes/No**

If yes, please give details:
……

Continue overleaf

9. Are there any other aspects of your health that you think Skin Tech should know about? **Yes/No**

If yes, please give details:
……

For completion by your Skin Tech Clinician:
Other Clinical Information; Notes

1. Identification of skin type.
2. Identification of photo type (Fitzpatrick Scale).
3. Identification of area to be treated.

Recommended Treatment (Notes)

TREATMENT SHEET

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Name……D O B……

Treatment No:	Date:	By:			Cost:	
Comments/Assessment						
		Date				
Area to be treated		% + Time	% + Time	% +Time	% + Time	% + Time

Assessment No:	Date:	By:	
Problems			
Effect			
Treatment Plan			

Treatment No:	Date:	By:	Cost:	
Comments/ Assessment				
	Date:			
Area to be treated	% +Time	% + Time	% + Time	% + Time

Assessment No:	Date:	By:	
Problems			
Effect			
Treatment Plan			