**HIFU/Electrical Facial Client Record Card**

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | |
| Telephone No: | E-mail: |
| GP Details: | |
| Emergency Contact Details: | |

**Skin Analysis**

**Dry** – *my skin is dry, flaky and often feels tight after washing.*

**Sensitive** – *my skin flares up easily, is often red, warm to touch and burns easily in the sun*

**Oily** – *my skin often has breakouts of spots and blackhead and has a shiny appearance*

**Combination** – *my skin has areas that are oily, usually around my forehead, nose and chin, my cheeks are either dry or with no imperfections.*

**Therapist notes:**

**Medical Questionnaire**

Please tick if you have any of the following:

Liver of Kidney Problems Heart or lung conditions Pacemaker/portable ECG

History of Thrombosis Haemophilia High/Low Blood Pressure

Thyroid Conditons Diabetes Epilepsy

Organ Transplants Botox Fillers

Recent Dermabrasion Recent laser treatments Recent surgery

Metal Plates or Pins Pregnant Phlebitis

Stroke Bells Palsy Melanoma

Eye Infections Cold Sore Acne Rosacea

Loss of Skin Sensation Nerve Damage Light Sensitive Headaches

Using Steroid Creams Impetigo Eczema/Psoriasis

Any other condition not listed (please state below)

Taking any medication (please list any medications taken below)

**Client Consent**

*The following points have been specifically discussed and I have had the opportunity to ask any questions concerning this information:*

* The HIFU treatment delivers a low amount of focussed ultrasound energy into the skin. The heat from the ultrasound stimulates new collagen to form. I understand that there can be discomfort during the treatment as the energy is being delivered into the skin. I have been advised by my therapist that painkillers may be taken to ease any discomfort.

Initial \_\_\_\_\_\_\_\_\_\_\_\_\_

* Immediately following a HIFU treatment the skin may appear red, slight swelling may be visible and there may be a tingling sensation or tenderness to the touch. These effects are temporary and usually resolve themselves within a few hours or up to 2 days.   
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_
* Occasional, temporary effects may include bruising or welts which generally resolve in hours to days, or numbness in the treatment area which resolves itself in days to weeks.  
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_
* As with any medical procedure, there are possible risks associated with treatment. There is a remote chance of a burn that may or may not lead to scarring (either of which will respond to medical care), or temporary nerve inflammation. Temporary muscle weakness may result after treatment due to inflammation of a motor nerve or temporary numbness due to the inflammation of a sensory nerve. These issues will generally resolve themselves within a few days and in some cases, up to 6 weeks.  
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_
* It has been explained to me that results vary from patient to patient and occasionally the collagen building on the inside that helps counter the effects of gravity does not always have a visible effect on the outside. I understand that the results with unfold over the course of 3 – 6 months and that some patients may benefit from more than one treatment.   
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_
* I understand that it is recommended to have the treatment carried out on an annual basis in order to preserve results and in line with the body’s natural aging process.  
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_
* I understand that the treatment is a non-invasive procedure and is not intended to produce the same results as an invasive surgical procedure.  
   Initial \_\_\_\_\_\_\_\_\_\_\_\_\_

**I now authorise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to begin my HIFU treatment.**

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIFU THERAPIST STATEMENT**:

I have fully explained to the patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the nature and purpose of the HIFU treatment and the potential risks associated to treatment. I have asked the patient if he/she has any questions regarding the treatment or risks and have answered those questions to the best of my ability.

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS SECTION IS FOR THERAPIST USE ONLY**

**Treatment Checklist**

Pre-treatment photographs taken

Procedure reviewed with patient

Patient questions answered

Informed consent form signed

Treatment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

Patient Record completed

**Follow Up Checklist**

Post-treatment photographs taken

Client aftercare provided

Follow up appointments scheduled (week 6 & week 12)

6-week photographs taken

12-week photographs taken

**Treatment Settings (Face)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **4.5mm** | **3.0mm** | **1.5mm** |
| **Neck** | N/A |  |  |
| **Under Chin** |  |  |  |
| **Cheeks** |  |  |  |
| **Forehead** | N/A |  |  |
| **Eyes** | N/A |  |  |
| **Lip** | N/A | N/A |  |

**Treatment Notes (Body)**

Cartridges used:

Power Settings: