**HIFU Vaginal Rejuvenation Client Record Card**

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

**Self Analysis**

Please tick the appropriate box:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **No Issues** | **Mild** | **Moderate** | **Severe** |
| **Vaginal Laxity** |  |  |  |  |
| **Vaginal Moisture** |  |  |  |  |
| **Vaginal Sensitivity** |  |  |  |  |
| **Bladder Weakness** |  |  |  |  |

**No of children**: **Natural Birth/C-Section**

**Ages of children:**

**Treatment Goals:**

**Therapist notes:**

**HIFU 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 Recent laser treatments Recent surgery

 Metal Plates or Pins Pregnant Stroke

 Bells Palsy Melanoma Autoimmune Disease

 Loss of Skin Sensation Nerve Damage Cervical Cancer

 HRT Menstruation STI’s

 Genital Modification Vaginal Prolapse Vaginal Warts/Genital Herpes

 Recent Vaginoplasty Recent Labiaplasty Vaginal Inflammation

 Vaginismus Candidal Vulvovaginitis FGM (female circumcision)

 Pubic Lice Thrush Infections

 Bartholins Cysts Coil Hysterectomy

 Open wounds or lesions Any other condition not listed (please state below)

 Taking any medication (please list any medications taken below)

Undergone any cosmetic procedures in the vagina: YES/NO (if yes give details including treatment dates below).

Are you currently taking the following prescription medications?

 Accutane within the last 12 months

 Anticoagulants or antiplatelet drugs

 Immunosuppressant Drugs

**Client Signature ……………………………………….. Date: ………………….**

**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 vagina 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 a few weeks. It is also normal to experience an influx of moisture for a few days post treatment.
 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 benefits 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS SECTION IS FOR THERAPIST USE ONLY**

**Treatment Checklist**

 Pre-treatment laxity test complete

 Procedure reviewed with patient

 Patient questions answered

 Informed consent form signed

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

 Patient Record completed

 What to expect information given to patient

**Follow Up Checklist**

 Client aftercare provided

 1 week follow up call scheduled for \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

 12 week follow up appointment scheduled for \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Laxity Test Results**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Reading 1** | **Reading 2** | **Reading 3** | **Average** |
| **Pre-Treatment** |  |  |  |  |
| **12 weeks** |  |  |  |  |

**Treatment Settings**

|  |  |  |
| --- | --- | --- |
| **Area** | **4.5mm** | **3.0mm** |
| **Section 1** |  |  |
| **Section 2** |  |  |
| **Section 3** |  |  |

**Clinical and Treatment Notes:**

**HIFU Therapist Signature ……………………………………….. Date: ………………….**