Cavitation Ultrasound Medical Consent

Name:		
Age:		
Address:		
Email:		
Mobile:		
Gp Name and address:		
Are you currently suffering from any of the following?		
Active infections		
Cancer or in recess for less than 3 years	Yes	No
Cold or flu symptoms	Yes	No
Diabetes 1 or 2	Yes	No
Fluid retention in area being treated.	Yes	No
High blood pressure	Yes	No
HIV	Yes	No
Hyperlipidaemia (raised serum levels of one or more of total cholesterol)	Yes	No
Immunosuppression (an act that reduces the activation or efficacy of the immune system	Yes	No
Joint Replacements	Yes	No
Medications	Yes	No
Menstruation	Yes	No
Metallic Implants in the area being treated	Yes	No
Pacemaker	Yes	No
Pregnancy, or breast feeding or chance of being pregnant	Yes	No
Skin allergies or inflammation	Yes	No
Swollen lymph nodes	Yes	No

During your treatment you may find the following occur, ringing in the ears. This is caused by the sound waves passing from the skeleton to the ear sensation of heat. This is caused by the energy produced from the broken fat cells as they are imploding. This will stop soon after treatment. Stinging on the skin surface, this happens where the nerves located in the epidermis react with the cooling gel. This will not cause major discomfort and will cease after treatment redness on the surface of the skin. This is heat related and should vanish within 2

hours after treatment. The treatment can also cause mild bruising in some individuals although this is rare. Cavitation is not a weight loss treatment and results will only be effective if you follow the aftercare we provide to you. Please remove any jewellery or hearing aids before treatment.

Are you or anyone in your household suffering from any covid 19 symptoms? Y/N

If yes please do not attend your appointment.

Please do not book your appointment 2 weeks prior to your covid19 vaccine and 3 weeks after having received the vaccine.

Please bring proof of age and ID

All medical and consent forms will be stored securely for 7 years.

At Brows and Beauty by Nicky B we take your privacy seriously and will only use your personal information to administer your records and to provide the treatments and services you have requested from us. However, from time to time we would like to contact you with details of our latest promotions and treatments that we provide. If you would prefer to be excluded from any future marketing projects that we undertake please tick here ………

I confirm the health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the therapist agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the therapist before any further treatments are carried out. I agree that I understand the treatment I am having today.

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

Practitioner Signature: ……………………………………………………………………… Date…………………………………………..

Practitioners Notes: Drs consent required? Y/N

Medications:

Health conditions: