**DERMAPLANING CONSULTATION FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to contact you or leave a message? YES/NO

Do I have permission to show non identifying photos? YES/NO

CONCERNS (please circle)

 ACNE LARGE PORES ACNE SCARRING DEHYDRATED SKIN CYST/NODULES AGE SPOTS OILY SKIN MELASMA REDNESS DULL COMPLEXION BLACKHEADS EXCESSIVE FACIAL HAIR ROSACEA BODY ACNE ROUGH/UNEVEN SKIN TEXTURE MILIA SUN DAMAGE FREQUENT BREAKOUTS

 OTHER.............................................................................................................................

How would you describe your skin? (Please circle)

 OILY DRY COMBINATION SENSITIVE

How would you describe your stress levels? (Please circle)

 LITTLE MODERATE HIGH SEVERE

Are you currently under the care of a GP? YES/NO

Details.............................................................................................................................................................................................................................................................................................

Are you currently under any medications, either topical or oral? YES/NO

Details.............................................................................................................................................................................................................................................................................................

Do you have any allergies to food/medication? YES/NO

Details.............................................................................................................................................................................................................................................................................................

Ethnic background.....................................................................................................................

Do you smoke? YES/NO

Are you prone to cold sores? YES/NO

Do you have an allergy to latex? YES/NO

Do you tan regularly (in the sun or on tanning beds?) YES/NO

Are you claustrophobic? YES/NO

Are you epileptic? YES/NO

Have you ever taken a reaction to a facial or body treatment before? YES/NO

Have you received a face peel in the last 14 days? YES/NO

Have you received any laser treatments in the last 4 weeks? YES/NO

Details ...................................................................................................................................

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Which skin care routines do you use?

CLEANSER TONER MOISTURISER FACIAL OIL SERUM SPF

EYE CREAM EXFOLIATION SCRUB SELF TANNER ENSYMES MAKEUP

OTHER.......................................................................................................................................

I ........................................give my permission for the following treatment, DERMAPLANING, to be performed by.............................................................I understand the treatment procedure and the benefits of it, and there are reasons I cannot have this treatment performed on me, including but not limited to diabetes, cancer, active acne, a history of bleeding disorders and the inability for blood to coagulate following an injury and sunburn/windburn skin, therefore I have disclosed everything in this form. Certain medications including blood thinners, higher dosages of Aspirin and Accutane are contraindicated for this treatment due to the possibility of nicks or cuts.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

Client signature........................................................................DATE.......................................

Practitioners signature ............................................................DATE.......................................

DERMAPLANING CONSENT

I understand that Dermaplaning involves the use of surgical blade to remove fine vellus hair and dead layers of skin from the face. The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction. I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Client will be notified and the area will be treated if necessary. The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth pattern, I understand that the treatment can cause activation of cold sores?

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age.

I agree and adhere to all safety precautions and regulations during the skin treatment. I have received and understand the post care recommendations as follows: no sun exposure for 48 hours, moisturise as needed, use gentle cleanser only, Alpha and Beta Hydroxyl acid (if desired) may be resumed 48 hours after treatment. Use of sunscreen is highly recommended post-treatment for at least next 7 days. (SPF30 and above)

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

Practitioners Signature: ........................................... Date:

CLIENTS NAME..................................................................................................

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| --- | --- | --- |
| **TREATMENT DATES** | **CHANGES SINCE LAST TREATMENT (medication etc.)** | **NOTES/PRODUCTS USED &RECOMENDATIONS** |
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**Dermaplaning pre- treatment instructions:**

No shaving, laser treatment, peeling, waxing, peels or aggressive exfoliations one week prior to dermaplaning treatments.

You should wait 14 after receiving Botox or derma fillers before having your dermaplane treatment.

**Dermaplaning post- treatment instructions:**

No recovery time you may resume your normal activities immediately after your treatment.

Use a gentle cleanser and apply moisturiser at least twice daily for a minimum of 7 days after your dermaplane treatment.

Avoid excess heat, sauna, sun beds/ steam rooms, sun exposure for a minimum of 3 days after your dermaplane treatment.

If you must be in the sun apply SPF 50 often, re apply often, wear a hat and seek shade when possible.

Avoid facial waxing for 7 days.

No scrubs, peels or aggressive brushes for 7 days.

Do apply serums as absorption levels will be elevated.

Be careful with self tan; remember absorption levels will be elevated.

You might experience a slight windburn sensation after the post treatment and skin care products may tingle slightly – this is normal for the first few days.

For best results Dermaplane Treatment are recommended every 4 to 6 weeks.