Consultation Form: Shrinking Violet Wraps

NAME:	
ADDRESS:	
TELEPHONE NUMBER:	EMAIL ADDRESS:
DATE OF BIRTH:	OCCUPATION:
EMERGENCY CONTACT:	DOCTORS NAME/SURGERY:

We aim to ensure clients have the best possible advice both prior to and post-treatment. Please read the following information prior to booking an appointment in the salon.

- **Consultation Information:** to ensure you are not contraindicated to any treatment.
- **Pretreatment Advice:** should be read prior to attending an appointment.
- **Aftercare Advice:** to be read following your appointment for best results.

Children under the age of 16 should have consent from a parent or guardian prior to any appointment.

CONSULTATION

- **Local Contraindications**: treatments cannot be performed over contraindicated areas.
- **Medical Contraindications**: please seek medical advice prior to booking. In circumstances where medical permission cannot be

obtained, clients must give their informed consent in writing.
- **Total Contraindications**: prohibit a treatment from taking place.

Local Contraindications:

- Varicose veins
- Bruising
- Cuts/Abrasions

Medical Contraindications:

- Check any condition that is already being treated by a GP or another practitioner.
- Thyroid Problems
- Asthma
- Claustrophobia

Total Contraindications:

- Soya Bean Intolerance
- Sunburnt or Wind Chapped Skin
- Active Skin Conditions (Eczema, Dermatitis, Psoriasis)
- Recent Surgical Operations
- Inflammation or Swelling
- Low/High Blood Pressure
- Pregnancy
- Breastfeeding
- Chemotherapy
- Claustrophobia
- Lymph Gland Removal

On completion of this consultation card you must tick the Consent Box in order for the treatment to take place.

By ticking the box, you are agreeing to the following terms and conditions.

I accept that any treatment I have has been fully explained to me and will be undertaken at my own risk. I have carried out a patch test (where

necessary) and I am satisfied with the explanation of the procedure and the aftercare. I have answered the questions regarding my medical history to the best of my knowledge and accept that failure to disclose relevant information may impact treatment results.

I agree to contact Sutherlands Hair and Beauty immediately in the event of any adverse effects.

I agree to these terms and conditions (Please tick)