sutherlands HAIR&BEAUTY

Consultation Form: Dermalux LED Light Therapy

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

This form is designed to help assess your skin type and your needs and expectations of the DermaluxTM treatment.

1. Client skin type

Skin type	Complexion description
Type 1	Very pale, always burns, never tans
Type 2	Fair skin and hair, burns easily, tans minimally
Type 3	Slightly darker skin, burns sometimes, tans gradually
Type 4	Mediterranean; burns rarely, tans easily
Type 5	Asian/Arabic: burns rarely, always tans
Type 6	Afro-Caribbean; never burns, always tans

2. Which skin care products do you use…

a. On The Face? ____

b. On The Neck? ____

c. Do you regularly use a face cream with an SPF?
Y/N

3. Have you undergone any cosmetic/aesthetic treatments in the last 24 hours? Y/N

If YES please list.

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4. Are you currently undergoing any other aesthetic treatments?
Y/N

If YES please list.

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5. Do you use sunbeds or are regularly exposed to sun?
Y/N

6. Do you smoke?
Y/N

7. What are your primary skin concerns?

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8. What are your goals and expectations of the treatment?

Treatment type:

Anti-Ageing/Acne & Blemish Prone/Skin Disorder/Post Treatment

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:

- N/A

Medical Contraindications:

- Check any condition that is already being treated by a GP or another practitioner
- Consult with a Doctor if you are taking any medication that may have an effect on skin sensitivity.
- Pregnancy (Dermalux™ LED devices have NOT been tested on pregnant women and therefore the risk to the foetus or pregnant women is unknown. It would be at your own discretion if you wish to book a treatment).
- Light induced migraines (although uncommon the light may induce a migraine attack).
- Are you currently taking St John's Wort or other herbal remedies? (St John's Wort taken in very large amounts (more than the RDA) may cause some people to be slightly more sensitive to light).
- Nervous/Psychotic conditions.
- Anti Arrythmic drugs (Codarone, Aratac, chlorpromazine) If yes it is at your discretion whether you commence a Dermalux™ treatment.
- HMG-CoA reductase inhibitors (Statins (atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin)) If yes the treatment can still be administered at the discretion of the client as long as they report no increased sensitivity to sun since commencing statins.
- Anti-inflammatory (topical) (Ketoprofen, Oruvail) (do not apply LED treatment directly over gel).
- Epidermal growth factor receptor inhibitors (treatment for lung cancer) Please consult your physician before commencing a course of Dermalux™).
- Medication Cautions - treatment can be administered as long as the medication has not been taken in the last 5 days
- Antibiotics (Tetracyline group: Doxyclyline, Oxytetracycline, Lymecycline etc) (Quinolone group: Ciprofloxacin, Ofloxacin, Levofloxacin) (Sulfonamides: sulfamethoxazole/trimethoprim).
- Non-steroidal anti-inflammatory drugs (NSAIDs) (Naproxen, Celecoxib)
- Diuretics (Furosemide, Bumetanide, Hydro-chlorothiazide)
- Retinoids Tretinoin (Topical) (Roaccutane/Accutane, Retinova, Retin A gel).
- Anti-arthritic (Azathioprine)
- Anti-Cancer drugs (Ledertrexate/Methotrexate)
- Antifungals (Terbinafine, Itraconazole, Voriconazole, Griseofulvin (Grisovin))
- Anti-Psychotic (Chlorpromazines: Thorazine Sonazine)

Total Contraindications:

- Contagious diseases (Impetigo, Scabies, Chicken Pox, Mumps).
- Under the Influence of alcohol or drugs.
- Epilepsy or seizures triggered by light.

- Photosensitive disorders such as Porphyria, Lupus erythematosus, photosensitive eczema and Albinism.
- Discoid lupus
- Auto immune and metabolic disorders, whichcan give rise to light induced rashes.
- Anti-arthritic medication (Ridaura, Gold 50)

Declaration

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 both the above cautionary advice and 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 have read the Client information leaflet and have completed the consultation with my Provider. The treatment has been personally described to me by my Provider. I understand that the procedure can result in an appearance enhancement and is typically used to rejuvenate the skin and resolve problem skin conditions. I understand the benefits and likely clinical outcome of the DermaluxTM treatment and that multiple treatments are necessary to achieve optimal results. I understand that immediately after the Dermalux™ treatment my skin may feel warm and appear slightly red, although this is not normally expected. I understand that there is a small risk that light sensitivity and/or hyperpigmentation of the skin can occur after the procedure, although this is not normally expected. I understand that if I am taking any medication listed that state, I carry a greater risk of a light sensitivity reaction and it is at my discretion whether I commence a DermaluxTM treatment. I understand that the DermaluxTM LED devices have NOT been tested on pregnant women and therefore the risk to the foetus or pregnant women is unknown. I understand that if during the course of treatments I develop persistent headaches or some puffiness/itching or prolonged redness of the skin, I may be showing signs of light sensitivity and must notify my Provider immediately and discontinue treatment. I understand that I MUST inform my providers of any side effects that I feel are worse or unanticipated as soon as I am aware of them. I understand that withholding necessary

information about my health and medication may increase my risk of possible side effects. I will inform my Provider before every treatment if there has been any change to my circumstances and/or medication I may be taking. I agree that I have read and understood all the information provided. My questions have been answered satisfactorily and I have made an informed decision undergo to the DermaluxTM treatment.

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)