Treatment Consultation & Consent Form

Before commencing a Dermalux® treatment we highly recommend that you complete this form as part of your routine Consultation and Client Consent.

There are 2 parts to the form; the Consult and Consent.

1. The Consultation form is designed to help assess your client's skin type and suitability for Dermalux®
2. The Consent form is required for ethical and legal reasons. Patients/clients must be given enough information to be fully informed before deciding to undergo a treatment, and this informed consent must be documented in writing.

Both parts of this form need to be signed by the client before commencing a Dermalux® treatment.

Client details

Title Miss/ Ms/Mrs/Mr/Other

First Name Surname

DOB

Address

Postcode

Telephone Mobile

Email

Doctor's name and address

Emergency Contact Name

Relationship

Emergency Contact Telephone Number

PART 1 Consult

This form is designed to help assess your skin type and your needs and expectations of the Dermalux® 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. Face?

    b. 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.

_____

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

If YES please list.

_____

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?

_____

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

_____

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

Precautions and Contra–indications for Dermalux® treatments.

There are some instances and some conditions in which Dermalux® LED Phototherapy may prove unsuitable for an individual. Certain medical conditions or drugs you may be taking may mean that you are unsuitable for the treatment because it may make you sensitive to the light produced by Dermalux®

Precautions due to drug induced photosensitivity.

Please indicate if you are or have taken any of the following medication;

REF	Drug Type	Specific group or common name	Y/N	Comments
1	Antibiotics	Tetracyline group: Doxyclyline, Oxytetracycline, Lymecycline etc		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
		Quinolone group: Ciprofloxacin, Ofloxacin, Levofloxacin		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
		Sulfonamides: sulfamethoxazole/trimethoprim		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
2	Non-steroidal anti-inflammatory drugs (NSAIDs)	Naproxen, Celecoxib		If yes, the treatment can be administered as long as the medication has not been taken in the last 5 days
3	Diuretics	Furosemide, Bumetanide, Hydro-chlorothiazide		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
4	Retinoids Tretinoin (Topical)	Roaccutane/Accutane Retinova, Retin A gel.		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
5	Anti-arthritic	Azathioprine		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
6	Anti-Cancer drugs	Ledertrexate/Methotrexate		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
7	Antifungals	Terbinafine, Itraconazole, Voriconazole, Griseofulvin (Grisovin)		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days

REF	Drug Type	Specific group or common name	Y/N	Comments
8	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
9	Anti-Psychotic	Chlorpromazines: Thorazine Sonazine		If yes the treatment can be administered as long as the medication has not been taken in the last 5 days
10	Anti Arrythmic drugs	Codarone, Aratac, chlorpromazine		If yes it is at your discretion whether you commence a Dermalux™ treatment
11	Anti-inflammatory (topical)	Ketoprofen, Oruvail		If yes do not apply LED treatment directly over gel.
12	Epidermal growth factor receptor inhibitors (treatment for lung cancer)	Cetuximab, panitumumab, erlotinib, gefitinib, lapatinib, vandetanib		If yes please consult your physician before commencing a course of Dermalux™
13	Anti-arthritic	Ridaura, Gold 50		If yes the treatment cannot be administered

Precautions and Contra –indications for Dermalux® treatments.

There are some instances and some conditions in which Dermalux® LED Phototherapy may prove unsuitable for an individual.

1. Do you suffer from epilepsy or seizures triggered by light? Y/N
2. Do you suffer from a photosensitive disorder? Y/N
   A photosensitive disorder describes a condition which means that you are sensitive or react to normal amounts of light. Photosensitive disorders include Porphyria, Lupus erythematosus, photosensitive eczema and Albinism.

If you answered YES to any of these questions, then unfortunately you are not suitable for Dermalux®.

3. Are you Pregnant? Y/N

If you answered YES, then it is at your discretion whether you commence a Dermalux® treatment. Dermalux® LED devices have NOT been tested on pregnant women and therefore the risk to the foetus or pregnant women is unknown.

4. Do you suffer from light induced migraines? Y/N
5. Are you currently taking St John's Wort or other herbal remedies? Y/N

If you answered YES to any of these questions, then it is at your discretion whether you commence a Dermalux® treatment.

- Although uncommon the light may induce a migraine attack.
- St John's Wort taken in very large amounts (more than the RDA) may cause some people to be slightly more sensitive to light.

I confirm that I have answered all the questions to the best of my knowledge and understand that withholding necessary information about my health and medication may increase my risk of possible side effects.

Client Signature……

Print Name……..

Date……

Physician/Nurse/Aesthetician Signature ……

Print Name ……

PART 2 Client Consent

	Initials
• 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 Dermalux® 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 in 1-10 **Precautions due to drug induced photosensitivity.** I am aware that I carry a greater risk of a light sensitivity reaction and it is at my discretion whether I commence a Dermalux® treatment**.**	
• I understand that the Dermalux® 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 Dermalux® treatment.	

Client Signature……Client Name……

Provider Signature…… Provider Name……

For (Clinic name)……

Date ……