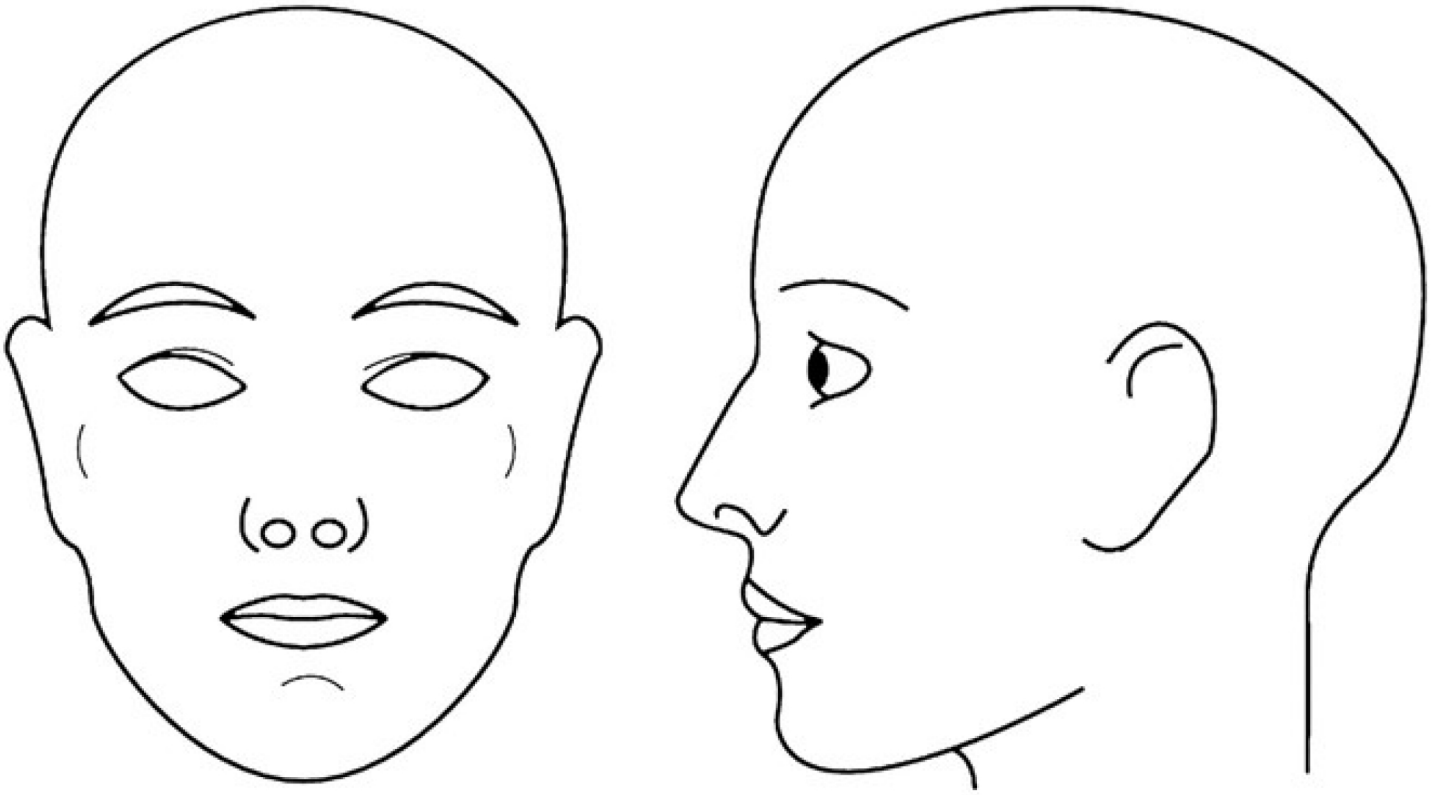
Areas Of Concern and Client Expectations



Head Office
Lynton House, Manor Lane,
Holmes Chapel, Cheshire CW4 8AF
Tel +44 (0)1477 536977
info@lynton.co.uk

clinical@lynton.co.uk www.lynton.co.uk

FOCUS DUAL CONSULTATION FORM

Surname _____ First Name _____

Mr/Mrs/Miss/Other _____ DOB ___/____/_____

Home Address _____

_____ Postcode _____

Home Tel No _____ Mobile Tel No _____

Email _____

Emergency Contact Name & Phone Number _____

Ethnic Origin _____ Occupation _____

Treatment Requested (Please Circle)

Lax skin / Lines & wrinkles / Skin lifting / Fat reduction /
General rejuvenation / Other

Body Area(s) _____

Comment _____

Lifestyle & Medical History – Please Tick Any That Apply to You:

Pigmentation (e.g. Melasma / Vitiligo)	☐	Skin Disorders (e.g Eczema / Psoriasis)	☐
Open Wounds / Active Infection	☐	Heart Conditions or Cardiovascular Disease	☐
Keloid Scarring	☐	Vascular Disease (e.g Haemophilia)	☐
Pregnant or Breastfeeding	☐	Rosacea or Severe Thread Veins	☐
History of Cancer	☐	Communicable Diseases (e.g. Hepatitis / HIV)	☐
Autoimmune Disease	☐	Herpes (e.g Shingles / Cold Sores)	☐
Diabetes	☐	Acne	☐
Epilepsy	☐	Botox / Injectables	☐
Pacemaker	☐	Thread Lifts	☐
Metallic Prosthetsis or Implants	☐	Semi-Permanent Makeup	☐
Bell's Palsy or Other Facial Paralysis	☐	Chemical Peel / Microdermabrasion	☐
		Regular Smoker	☐

Allergies (Please Detail) _____

_____

Products Used & Other Comments _____

_____

_____

Lynton

Are You:

Currently Taking Any Medication or Any Supplements?

No/Yes (Please Specify the Condition & Medications) _____

_____

Currently Using/Used in The Last 6 Months, Any of The Following? (Please Circle):

Anticoagulants / Oral or Topical Retinoids (e.g Roaccutane or Retin A) / Oral or Topical Steroids

Comments: _____

Recovering From Any Major Medical Treatment Within the Last 6 Months?
No/Yes (Please Specify) _____

Does The Area for Treatment Have: (Please Circle)

Moles / Birthmarks / Tattoos / Semi-Permanent makeup / Chemical peel / Botox / Fillers / Piercings / Metallic Implants

_____

Skin Disorder/Disease? No/Yes _____

Had Previous Aesthetic Treatment? No/Yes _____

Your Skin:

What Products Do You Use on Your Skin? _____

Please INDICATE how your skin responds to midday summer sun exposure with no sunscreen:

- ☐ Skin Type 1 Always burns, never tans
- ☐ Skin Type 2 Easily burnt, eventually gets a moderate tan
- ☐ Skin Type 3 Sometimes burns, quickly gets an average tan
- ☐ Skin Type 4 Rarely burns, quickly gets a deep tan
- ☐ Skin Type 5 Very rarely burns, consistent tan
- ☐ Skin Type 6 Never burns, consistent tan

Do You Currently Have a Real or Fake Tan? Yes/ No _____

How Long Ago Was Your Last UV Exposure? _____

What Are Your Goals/Expectations for The Treatment?

_____

_____

_____

Where Did You Hear About the Clinic? Recommendation/Advert/Leaflet/Press/Other _____

Pre-Treatment Check List

To Be Completed by The Operator (Tick to Confirm Points Have Been Discussed)

- ☐ How Treatment Works
- ☐ Pre/Post Treatment Care
- ☐ Typical Number of Treatments / Intervals
- ☐ Likely Clinical Outcome
- ☐ Sensation During Treatment
- ☐ Possible Side Effects
- ☐ Cost Per Treatment _____
- ☐ Photograph Taken
- ☐ Further Questions?

Comments _____

_____

_____

Informed Consent for Treatment

Please Read This Consent Form and Tick Each Box to Indicate You Understand and Accept the Information Contained Herein.

☐ The information I have given is correct to the best of my knowledge, and I have not withheld any known medical state or condition. I will inform the operator before treatment if there has been any change (for example in medications taken).

☐ I understand that the results from this treatment vary considerably and a small percentage of people may not respond satisfactorily to treatment.

☐ I understand multiple treatments are necessary to achieve optimal results.

☐ I understand that there is no guarantee of permanent results and maintenance treatments are often required.

☐ I understand that there may be short-term side effects such as bruising, prolonged-redness or swelling, as well as rare side-effects such as scarring or permanent discolouration. To date, there have been no reports of unwanted volume loss or temporary nerve paralysis with the Focus Dual system, but this cannot be ruled out completely.

☐ I understand I must use a high sun protection factor daily to avoid sun damage throughout the duration of the treatment course.

☐ I certify that I have read and understood all the information and my questions have been answered satisfactorily before signing this consent form. I consent to the terms of this agreement.

Client Name _____ Client signature _____

Operator Signature _____ Date _____

Lynton