ADVANCED SKIN TECHNOLOGY
A division of Device Technologies

# Clinical Strength Peels

## Consent
## Consultation
## Skin Analysis & Evaluation

# Forms

# Pre Peel Consent and Treatment Instructions

Patient and Clinic need a copy

**Client/Patient Name**_____

In order to achieve the best results possible from your peel treatment it is important that you read and understand the following instructions. If you have any questions regarding these instructions please contact your Skin Specialist/Physician for clarification.

**Clinic Number**_____ **Skin Specialist**_____

Please follow the instructions and guidelines provided by your Skin Specialist/ Nurse or Physician contained in your Starter Kit.

1. I understand that if, for any reason, I stop or interrupt the prep procedure I must contact my Skin Specialist immediately and notify them of any changes to my skin care regime. My appointment or type of peel may need to be changed or rescheduled.
2. I understand that a test patch must be done prior to treatment for Salicylic Acid and selected Vitamin A peels or where there is the possibility of an allergy.
3. I agree to **STOP, DISCONTINUE or NOT HAVE ANY OF THE FOLLOWING TREATMENTS:**

| **1 week prior to treatment** |
|---|
| Anti-wrinkle injections |
| Prescription topical Retin A |
| Home Needling |

| **2 weeks prior to treatment** |
|---|
| Waxing, bleaching or hair dying any areas to be treated |
| Depilatory use in any treated area |
| Electrolysis on any treatment area |
| IPL/Laser Hair removal treatments |
| IPL/Laser Skin Rejuvenation (Only prior to very superficial peels) |
| Sun exposure to area to be treated |
| Facial treatments of any kind including any AHA, BHA or Vitamin A treatments |
| Microdermabrasion / Epidermal Levelling |
| Hair colour or treatments of any type |
| Dermal Fillers |

| **4 weeks prior to treatment** |
|---|
| IPL/Laser Skin Rejuvenation (Only prior to Superficial to Medium Depth peels) |
| AHA, BHA, Vitamin A or TCA Superficial to Medium Depth Peels |
| In clinic Needling |

| **3-6 months prior to treatment** |
|---|
| Medical Needling |
| Fractional Ablative Laser Resurfacing |
| TCA or Phenol Deep Peeling |
| Facelift Surgery |

| **6-12 months prior to treatment** |
|---|
| Roaccutaine |
| Full Ablative Laser Resurfacing |

4. I will notify my Skin Specialist immediately if there is any change to my health, including the introduction of any new medications (topical or oral) or oral supplements as they may cause increased sensitivity to my peeling treatment,

**Client/Patient Signature**_____ **Date**_____

# Peel Consent Form

Clinic copy only

| I consent that: | |
|---|---|
| **Initial** | **Treatment** |
| | I have completed the client medical form **accurately**. |
| | I currently have no cold sores and if I have the Herpes Virus I will prep on an antiviral. |
| | I am not currently pregnant or breastfeeding. |
| | I have no allergies that will contraindicate me to having the treatment. Eg Salicylic acid |
| | I do not have open lesions, eczema or inflamed skin on the area to be treated. |
| | I understand that there are no guaranteed results from this treatment. Many variables exist such as age, sun damage, ongoing sun exposure, smoking, excessive alcohol intake, climate, diet and water intake, skin thickness and sensitivity. |
| | I understand the purpose of this peeling procedure is to exfoliate the outer surface of my skin which may or may not result in skin peeling or flaking as each case is individual. |
| | **I will not scratch, pick, pull at or abrade the treated skin.** |
| | I understand that direct sun exposure and use of a tanning booth is **prohibited** during this treatment time, and that a minimum SPF 15 **physical sun protection (no fragrance) must be applied daily.** |
| | I understand that **to achieve maximum results and to avoid complications** the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional the results could be altered or inhibitive. |
| | I understand that **it may take several treatments** to obtain the desired results. |
| | I understand that the following **side effects** can occur:<br>1. Discomfort<br>2. Redness and swelling<br>3. Itching or irritation<br>4. Skin peeling or flaking up to 14 days after the procedure<br>5. Hyperpigmentation<br>6. Acne Breakouts |
| | I understand the following **complications** can occur, although are very rare. I also understand that if they are to occur I accept sole responsibility for any medical care that may become necessary. I will immediately contact the Doctor, Nurse or Skin Specialist performing the treatment.<br>1. Hypopigmentation<br>2. Infection<br>3. Scarring |
| | I understand the goals of the treatment as well as the limitations and possible complications. |
| | My Skin Specialist has provided the information and has answered all my questions concerning this procedure. I clearly understand the above information |

I understand the cost of the treatment and the fee structure has been explained to me.
Cost of Treatment: $_____ Series of____ Cost: $ — — ——— — —

I have read and understand this agreement and all of my questions have been answered. I agree to these terms and I want to proceed with this procedure as indicated.

**Client/Patient Signature**_____ **Date**_____

# Post Peel Treatment Instructions

Patient and Clinic need a copy

In order to achieve the best results from your peel treatment we ask that you read and understand the following instructions. Your Skin Specialist/Physician will review the relevant post treatment protocol with you.

1. Your recovery time will be influenced by the type of peel treatment you have received and your individual skin's response. Your Skin Specialist will have discussed with you the individual time frame you should expect.
2. I agree to **STOP, DISCONTINUE or NOT HAVE ANY OF THE FOLLOWING TREATMENTS:**

| **For 24 hours post treatment** |
|---|
| Exercise (avoid getting overheated) |
| Bathing or Showering |

| **For 5-10 days post treatment** |
|---|
| Exfoliating products (scrubs, AHA's, BHA's, Vitamin A) |
| Products not recommended by my Skin Specialist |
| Home Needling |
| Anti-wrinkle injections |
| Prescription topical Retin A |
| Sun exposure to area treated |

| **2 weeks post treatment** |
|---|
| Waxing, bleaching or hair dying any areas to be treated |
| Depilatory use in any treated area |
| Electrolysis on any treatment area |
| IPL/Laser Hair removal treatments |
| IPL/Laser Skin Rejuvenation (Only prior to very superficial peels) |
| Facial Treatments of any kind including any AHA, BHA, Vitamin A or TCA treatments |
| Microdermabrasion / Epidermal Levelling |
| Hair colour or treatments of any type |
| Dermal Fillers |

| **4 weeks post treatment** |
|---|
| IPL/Laser Skin Rejuvenation (Only prior to Superficial to Medium Depth peels) |
| AHA, BHA, Vitamin A or TCA Superficial to Deep Peels |
| Needling (Standard In clinic or Medical) |
| Fractional Ablative Laser Resurfacing / Full Ablative Laser Resurfacing |
| Facelift Surgery |

3. I also agree to:-
    a. NOT TO PICK AT SKIN
    b. Increase water intake to include "at least" 8 glasses
    c. Wear Physical Sun Protection and reapply every 2 hours
    d. Not use wash cloths, or any other type of cloth on skin, instead, apply cleanser to clean hands and foam for application.

Additional Instructions:

_____

_____

_____

I understand and agree to comply with the above instructions. I also agree to contact the clinic with any further questions.

**Client/Patient Signature**_____ **Date**_____
**Clinic Ph Number**_____ **Skin**
**Specialist**_____

# Patient Profile

Clinic copy only

## Personal Details

Name: _____ Date: _____

Phone: _____ DOB: _____ Sex: F / M

Street Address: _____

Suburb: _____ State: _____ P/code_____

Email Address:_____

## Lifestyle

What is your occupation? _____

Do you participate in vigorous sports or aerobic activity? _____

Do you go to tanning booths?_____

Are you currently sun or wind burnt: _____

## Current or Previous Treatments

Do you get facial waxing/electrolysis/or use depilatories? _____
**(Wait 14 days between treatments.)**

Have you had any light based therapy treatments within the last 14 days?_____

If Yes, what sort? _____

Have you had any dermal fillers or Botox in the last week? _____

Have you ever had a peel before? _____ or within the last 14 days?_____

What kind? _____

Describe your reaction: _____

Have you had any other skin treatments such as Microdermabrasion, Epidermal Leveling or Dermal Needling within the last 14 days?_____

Have you had recent facial surgery?_____

## Medical History

Are you pregnant, lactating or trying to conceive? _____

Are you allergic to: (circle all that apply)
**Milk, apples, citrus, grapes, Aloe Vera, Aspirin, or any essentials oils?**

Any other allergies? If so, what? _____

What is your heritage? _____

How do you heal from a cut? (Circle one) **Brown pigment/ Pink then fades to white**

**Are you using/ have you used:**

- Prescription Retin A: _____ How frequently? _____

  Where do you apply it?_____

- Roaccutane: _____ How long for?_____
- Hormone/other medication: _____
- Glycolic or other AHA home care products. If so, which one(s)?

  _____

  How does your skin react to them?

  _____

Have you ever used any products that caused a bad reaction? Please describe:
_____
_____
_____

Do you smoke? _____ Get cold sores? _____

## Skincare

What is your home skincare regime?

AM_____
_____

PM_____
_____

What about your skin bothers you and what would you like to have improved?
_____
_____

## Treatment Recommendation

_____
_____
_____
_____

## Client/Patient Consent

Client/Patient Signature: _____

Skin Specialist: _____

Date: _____

Treatment 1:_____

**Please confirm that your profile including your medical history has not changed since your last treatment.**

Client/Patient Signature: _____

Skin Specialist:_____

Date: _____

Treatment 2:_____

**Please confirm that your profile including your medical history has not changed since your last treatment.**

Client/Patient Signature: _____

Skin Specialist: _____

Date: _____

Treatment 3:_____

**Please confirm that your profile including your medical history has not changed since your last treatment.**

Client/Patient Signature: _____

Skin Specialist: _____

Date: _____

Treatment 4:_____

**Please confirm that your profile including your medical history has not changed since your last treatment.**

Client/Patient Signature: _____

Skin Specialist: _____

Date: _____

Treatment 5:_____

**Please confirm that your profile including your medical history has not changed since your last treatment.**

Client/Patient Signature: _____

Skin Specialist: _____

Date: _____

Treatment 6:_____

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# Skin Analysis & Evaluation

Skin Specialist to complete

**Client/Patient Name**_____ **Skin Specialist**_____
**Date**_____

| | | | |
|---|---|---|---|
| **Sensitivity Test** | | **Area** | |
| | Reactive (flushes with touch) | | |
| | Impaired Barrier (stings &burns) | | |
| | Unresponsive (no sensation) | | |
| **Dehydration** | | | |
| | None | | |
| | Superficial to Medium | | |
| | Asphyxiated | | |
| **Skin Thickness (Stratum Corneum)** | | | |
| | Normal | | |
| | Slightly Thick | | |
| | Thickened | | |
| **Dermal Thickness & Tone** | | | |
| | Thin & Fragile | | |
| | Thick & Firm | | |
| **Keratinisation** | | | |
| | Normal | | |
| | Hyperkeratinisation | | |
| | Eczema | | |
| | Psoriasis | | |
| | Keratosis Pilaris | | |
| | Solar/Actinic Keratosis | | |
| **Pore Size** | | | |
| | Very Fine | | |
| | Enlarged | | |
| | Sebaceous Hyperplasia | | |
| **Lipid System** | | | |
| | Very Little | | |
| | Excessive | | |
| | Lipid Dry | | |
| **Acne Grade** | | | |
| | Grade I (open & closed comedones) | | |
| | Grade II (inflammatory, papules & minor pustules) | | |
| | Grade III (inflammatory, mainly pustules) | | |
| | Grade IV (cystic) | | |
| **Vascular System** | | | |
| | Normal | | |
| | Couperose (Diffused Redness) | | |
| | Telangiactasia (Dilated capillaries) | | |
| | Erythema (Intermitant redness) | | |
| | Dark circles (Deep Blue) | | |
| **Rosacea Stage** | | | |
| | Stage I (Persistant erythema) | | |
| | Stage II (Papules) | | |
| | Stage III (Phymatous) | | |
| | Stage IV (Ocular) | | |
| **Hyper-pigmentation** | | **Area** | **Epidermal/Dermal** |
| | Ephelides (Freckles) | | |
| | Chloasma (Pregnancy mask) | | |
| | Solar Lentigo (Age spots) | | |
| | Post Inflammatory (PIH) | | |
| | Dark Circles (Perioribital Melanosis) | | |

## Fitzpatrick Skin Types:

| Type | Complexion | Hair & Eyes | Erythema Potential | Tanning Potential |
|---|---|---|---|---|
| **I** | White<br>Very fair<br>Freckles<br>Celtic/Anglo | Blue eyes<br>Red or blond hair, | Always Burns | Never tans |
| **II** | White<br>Light or fair skin<br>Freckles<br>Celtic/Anglo | Blue, green or hazel eyes<br>Red or blond hair | Always Burns | Tans slightly |
| **III** | White<br>Cream to Olive<br>Eurpoean | Any hair or eye colour | Burns moderately | Tans gradually |
| **IV** | Brown<br>Light to Medium<br>Mediteranian or Asian | Brown hair and eyes | Seldom Burns | Tans well |
| **V** | Brown<br>Medium to Dark<br>Middle Eastern | Brown hair and eyes | Rarely Burns | Deep tan |
| **VI** | Black<br>African | Brown hair and eyes | Never Burns | Deep tan |

## Outline conditions and areas of concern: