

Treatment Evidence Form

iUBT353 – Remove hair using waxing techniques

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Last visit to the doctor:						
GP Address:						
Number of children: (If applicable)						
Date of last period: (If applicable)						

Contra-indications requiring medical permission – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):

Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Trapped/pinched nerve <input type="checkbox"/>
Haemophilia <input type="checkbox"/>	Nervous/psychotic conditions <input type="checkbox"/>	Inflamed nerve <input type="checkbox"/>
Any condition already being treated by a GP or another practitioner <input type="checkbox"/>	Recent operations <input type="checkbox"/>	Severe varicose veins <input type="checkbox"/>
Medical oedema <input type="checkbox"/>	Diabetes <input type="checkbox"/>	

Contra-indications that restrict treatment – (Select if/where appropriate):

Fever <input type="checkbox"/>	Bruises <input type="checkbox"/>	Neuralgia <input type="checkbox"/>
Infectious or contagious diseases <input type="checkbox"/>	Abrasions <input type="checkbox"/>	Hypersensitive skin <input type="checkbox"/>
Under the influence of recreational drugs or alcohol <input type="checkbox"/>	Scar tissue (2 years for major operation and 6 months for a small scar) <input type="checkbox"/>	Loss of skin sensation <input type="checkbox"/>
Any known allergies <input type="checkbox"/>	Sunburn <input type="checkbox"/>	Vascular skin <input type="checkbox"/>
Infectious skin diseases and disorders <input type="checkbox"/>	Self tan <input type="checkbox"/>	Varicose veins <input type="checkbox"/>
Undiagnosed lumps and bumps <input type="checkbox"/>	Heat rash <input type="checkbox"/>	48 hours after sun tanning <input type="checkbox"/>
Localised swelling <input type="checkbox"/>	Hairy moles <input type="checkbox"/>	Abnormal hair growth <input type="checkbox"/>
Inflammation <input type="checkbox"/>	Hormonal implants <input type="checkbox"/>	Recent fractures (minimum 3 months) <input type="checkbox"/>
Cuts <input type="checkbox"/>	Bell's palsy <input type="checkbox"/>	Steroid based medication <input type="checkbox"/>
Thin and/or fragile skin <input type="checkbox"/>		

Patch test:

Positive <input type="checkbox"/>		Negative <input type="checkbox"/>	
Brand of wax used:		Area tested:	
		Date of test:	

Area waxed (select if/where appropriate):

Full leg <input type="checkbox"/>	Underarm <input type="checkbox"/>	Upper lip <input type="checkbox"/>	Bikini line <input type="checkbox"/>
Half leg <input type="checkbox"/>	Forearm <input type="checkbox"/>	Chin <input type="checkbox"/>	Eyebrows <input type="checkbox"/>
Other <input type="checkbox"/>			

Methods used:

Hot wax

☐

Cool wax

☐**Treatment details – *(To include products used):*****Client feedback:****After/home care advice given:**

Therapist/learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	31/10/2019	First published	Qualifications Administrator