CLIENT CONSULTATION – LASER TATTOO REMOVAL FORM

Name: _____ **Date:** _____

Address: _____ Date of Birth: _____

Suburb: _____ State: _____ Postcode: _____

Telephone: Work:_____ Home: _____

Mobile _____ Other: _____

Email Address: _____

How did you hear about us? _____

□ Tattoo Removal **AREA OF BODY TATTOO IS SITUATED?** _____

□ Colours in tattoo _____

□ Approximate size of tattoo _____

Is the tattoo professional ☐ amateur ☐ traumatic ☐ surgical/medical ☐

Medical Background

Are you currently under a doctor's /healthcare practitioner's care? Yes: _____ No: ____

If yes, for what? _____

Talk about the following possible contra-indications to Laser/IPL treatments:

Have you had significant sun exposure in the last 4 to 6 weeks? Yes: _____ No: ____

Do you use spray-tanning products or tinted moisturisers? Yes: _____ No: ____

Do you have permanent makeup in areas to be treated? Yes: _____ No: ____

Do you smoke? Yes: _____ No: ____

Are you currently pregnant or trying to conceive? Yes: _____ No: ____

Client Signature: _____ **Date:** _____

Guardian Signature:_____ **Date:** _____

Clinician Signature:_____**Date:** _____

Distinctive Features
Cosmetic Tattoo and Beauty

Client Consultation Form

Name: _____ **Date:** _____

Have you ever experienced or been treated with / for the following:

Contra Indications:	**Yes**	**No**		**Yes**	**No**
Epilepsy			Photosensitising Drugs		
Keloid			Warfarin		
Pacemaker			Roacutane		
Skin Cancer			Cancer – current treatment		
Heart condition			Autoimmune disease		
Special Precautions:	**Yes**	**No**		**Yes**	**No**
Herpes [oral/genital] Cold Sores			Skin Disorder		
Diabetes			Aspirin		
Metal Implant/piercings			Medical Condition		
Anti Coagulants			Allergies		
Hormonal Condition			Skin Pigment – on treatment site		
Hormonal Medication			Anti-inflammatory Drugs		
Lack of Sensation			Lack of Temperature Awareness		
Allergy to topical anaesthesia			Immune system condition/problems		

If yes to any of the above, please explain and include dates / details:

_____

_____

Have you ever had any of the following on or near the treatment site:

Chemical Peel	Yes / No	Botox, injectables	Yes / No
Micro Dermabrasion	Yes / No	Resurfacing or fractional Laser	Yes / No
Implants	Yes / No	Surgery in treatment area	Yes / No

If yes, to any of the above, please explain and include dates / details:

_____

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Client Consultation Form _____ _____ Page 3

Name: _____ **Date:** _____

Please list all PAST medications used in the last 3 months:

Medication	For	Duration

Please list all CURRENT medications:

Medication	For	Duration

Please list all CURRENT vitamin supplements, herbal remedies:

Supplements / Remedies	For	Duration

NOTE: Any changes to medical history or medications must be notified.

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Client Consultation Form

Name: _____ **Date:** _____

Skin Type	Working Classification	Physical Characteristics
I	Always burns easily, never tans and is extremely sensitive to the sun	Red-haired, freckles, Celtic, Irish-Scots
II	Always burns easily, tans minimally, very sun sensitive skin	Fair-skinned, fair-haired, blue-eyed, Caucasian
III	Sometimes burns, tans gradually to light brown, sun sensitive skin	Average skin
IV	Burns minimally, always tans to moderate brown, minimally sun sensitive skin	Mediterranean-type Caucasian
V	Rare burns, tans well, sun insensitive skin	Middle Eastern, some Hispanics, some African American
VI	Never burns, deeply pigmented, sun insensitive skin	African American

Ethnic background: _____

Any other nationalities in family tree: _____

Eye colour: _____ Natural hair colour: _____

Natural skin colour on area that is unexposed to sun (area to be viewed): _____

Does skin burn easily with sun exposure: _____ Does skin tan easily: _____

If injured [burned, cut], does the skin heal leaving a dark, pigmented mark? _____

Does any close family member have skin that is darker or paler?_____

Fitzpatrick Skin Type assessed as: _____

_____

Client Signature: _____ **Date:** _____

Guardian Signature:_____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Client Consultation Form – Informed Consent _____Page 5

Name: _____ **Date:** _____

I _____ duly authorize staff of **The Distinctive Features Cosmetic Tattoo and Beauty** to perform tattoo removal, pigment reduction, or treat other skin conditions using a Q Switched tattoo laser.

I understand that Q switched Laser tattoo removal is relatively new medical cosmetic procedure and that long-term studies are ongoing. Past studies indicate that it is an alternative method for removing tattoo pigment/ink and reducing some pigmented conditions, and that results can very according to ink used, age of tattoo, area on the body that tattoo is situated, how the tattoo was created [professional, amateur, traumatic], health, life style, skin type as well as the medical condition of the client.

Skin pigmentation procedures need a doctor's approval prior to commencing treatment.

I have been advised of the following possible risks of Q switched Laser treatments:

		ClientInitials
1	The treatment may not produce permanent tattoo removal or permanent pigmentation reduction. Due to the nature of this treatment an exact result cannot be predicted and I acknowledge that no guarantees have been made to me as to the results that may be obtained.	
2	Possible side effects of the treated area can include mild temporary discomfort, redness or swelling. Textural changes and/or colour changes may develop.	
3	Colour changes, such as hyperpigmentation (brown / red discoloration) or hypopigmentation (skin lightening) may occur in treated skin. This may take many months or more to return to normal.	
4	Pinpoint bleeding, blistering, crusting, bruising and wound infection may occur. Scarring is a rare possibility.	
5	**Skin must be protected from the sun for 6/8 weeks before and after treatment. Unprotected sun exposure in the weeks pre and post treatment may produce hyper / hypo pigmentation.**	
6	A rare side effect is the possibility of a paradoxical darkening of the tattoo ink/pigments. This has been observed with treatment of pastel colour ink and on permanent make-up [ie lipline]	
7	Client must use proper eye protection as recommended by the laser manufacturer.	
8	I have received written client information / after care information.	
9	I agree to follow aftercare recommendations as directed by this clinic.	
10	My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment.	
11	I consent to photographs for the purpose of monitoring response to therapy.	

Client Signature: _____ **Date:** _____

Guardian Signature:_____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Client Consultation Form – Clinician to complete this page - Page 6

Name: _____ **Date:** _____

Heath assessment & suitability for treatment checked	☐	Sun avoidance explained	☐
Treatment process explained	☐	Hyper / hypo pigmentation and other side effects explained	☐
Program - Series of treatments sessions explained	☐	Fitzpatrick skin type explained & assessed	☐
Variability of results explained	☐	Informed Consent reviewed and signed	☐
Home care procedures explained	☐	Kirby-Desai scale	☐

Concerns _____

_____

Quote _____

Test Patches **Date performed…….**

Fitzpatrick Skin Type		Residual Tan		Tattoo colours			

Area	Wavelength	J/cm²	Spotsize	Pulse width	No of Shots	Clinician Sign
Test 1						
Test 2						
Test 3						

Comments immediately following test spots _____

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Follow up Assessment of test patches. Date ……..

Test 1 _____

Test 2 _____

Test 3 _____

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____