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 Date …………….

**EASY TCA SKIN TECH**® **CHEMICAL PEEL CONSENT FORM**

#### Name: Contact Details :

#### Address:

Date of Birth:

**Questionnaire:**

**PLEASE STATE THE DATE YOU HAVE HAD YOUR COVID VACCINATION OR VACCINATION DUE:**

**1ST HAD/DUE ………………………………….. 2ND HAD/DUE …………….…………………..**

**HAVE YOU OR ANYONE IN YOUR HOUSEHOLD HAD/OR HAVE COVID-19 ? ………………………………………………………………Yes/No**

**DO YOU HAVE OR HAVE YOU HAD A HIGH TEMPERATURE IN THE LAST 7 DAYS ?……………………..……………………………….Yes/No**

Are you pregnant or breast feeding? …………………………………………………………………………………………………….……………………..Yes/No

Have you undergone any treatments based on an active dermal response?…………………….………..………………….………………Yes/No

Date …………………………………..

Do you have any active inflammatory skin conditions incl. rosacea?………………………………………..…….…………………............. Yes/No

Details ………………………………………………………………………………………………………………………………………………………….………….……

Do you have any serious illnesses such as hepatitis, diabetes, autoimmune disease? ….………………….…………………….……. Yes/No

Details ………………………………………………………………………………………………………………………………………………………………………….

Have you ever had an allergies/ had allergic reaction? ……………………………………………………………………….…………………….. Yes/No

Details ………………………………………………………………………………………………………………………………………………………….…………….

Do you take any medication (inc. over the counter or herbal)? ……..………………………….………………………….………………..……Yes/No

Details ………………………………………………………………………………………………………………………………………………..……………………….

Do you use sun beds or sunbathe? …..………………………………………………………………………………………..……………………………… Yes/No

Do you or your family have a history of skin cancer ?....................................................................................................... Yes/No

Do you have any hypertrophic or keloid scarring? ……………………………………….……………………………..……………………..………. Yes/No

Have you ever had chemotherapy/radiotherapy? ………………………………………….………………………………….……………………… Yes/No

Have you used Roaccutane with in the last 6 months ?.................................................................................................... Yes/No

Have you used topical or systemic steriods ?.................................................................................................................... Yes/No

Have you received any hair dying or peroxide treatments in the last 7 days ?..................................................................Yes/No

Have you had hair removal in the last 7 days ? ………………………………………………….……………………………………….………………. Yes/No

**THE FOLLOWING POTENTIAL ADVERSE EVENTS HAVE BEEN FULLY EXPLAINED AND UNDERSTOOD BY ME:**

Possible side effects may include redness, itching, swelling, allergic reaction to the products, hyper pigmentation or hypo pigmentation.. I am aware that there may be peeling or flaking of the skin at approximately 3 days. However some may experience this from day 2 -7 depending on their response to the peel. I will advise my Practitioner should I experience any of the aforementioned adverse events and that I have made aware of any upcoming events that these side effects may have an impact on.

I am aware that the products used for this treatment contain Citric Acid, Vitamin C, Copper, Zinc, Cocamide, Sodium Laureth Sulphate, Saponines and Manganese. I understand that I may require four peels to reach the desired results and no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement not perfection.

**I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose.**

I consent to treatment with Easy TCA Skin Tech® as discussed with my Practioner regarding the procedure I will be undertaking, understand the information given, potential risks and that any medical terminology, questions or queries have been answered. I am aware of alterative treaments and that to have no treatment is one of those options.

All Client information is kept in compliance with the Data Protection Act. (2018)

**Client’s Signature:** …………………………………………………………… **Date**: ……………………………

**Treatment Record**:

Registered Office: 21 Marshall Road Mapperley Nottingham NG3 6HS Registered Company No: 06384862

Cost £ ………….

 **Treatment by Kairen Weston (Advanced Aesthetic Nurse Practitioner, Nurse Prescriber)**

**Signature …………………………………………………………………..…………… Date …………………………………** JUNE 2021