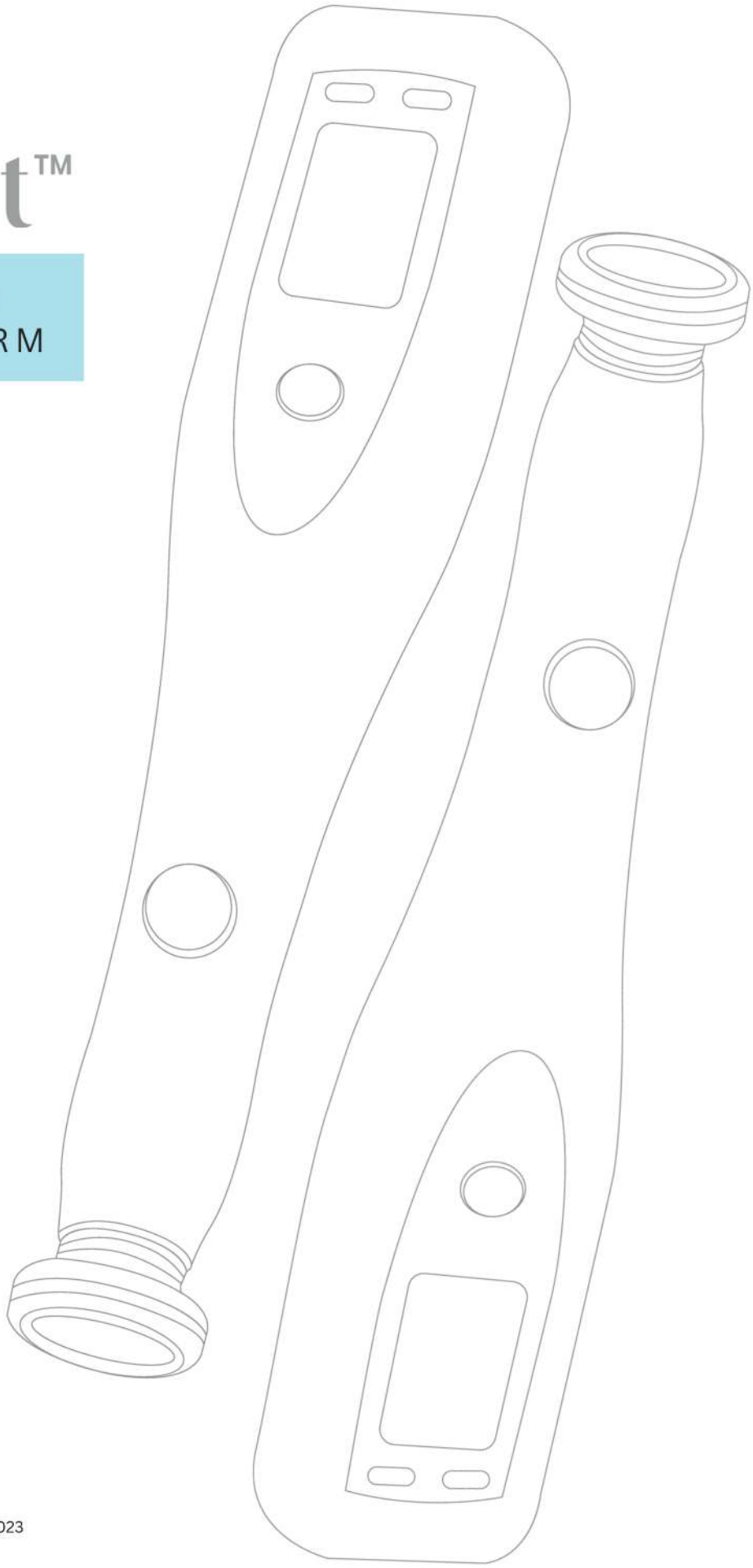
CoolJet™

CONSULTATION & CONSENT FORM



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CLIENT DETAILS

FULL NAME

ADDRESS

POSTAL CODE

TELEPHONE

MOBILE

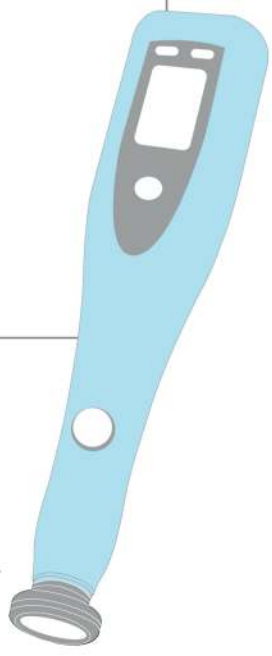
EMAIL

DATE OF BIRTH

OCCUPATION

AGE

TREATMENT AREA(S):



CONSENT

I understand that my specialist technician will be in direct contact with me in relation to the CoolJet treatment. This treatment involves the use of disposables. All equipment is sterilized before use, all surfaces involved in the process are protected, gloves will be worn at all times and my CoolJet. Technician will look to use medical asepsis conditions and no- touch technique throughout. In the UK, my specialist will follow guidelines as outlined in section 15 of the Local Government Act 1982 and any other legislation relevant elsewhere. I hereby give written consent to the specialist, who is a fully trained and insured CoolJet technician, to carry out the treatment of my choice as requested by me. I have observed that the device being used is a genuine and branded CoolJet by Louise Walsh device.

CLIENT SIGNATURE

TECHNICIAN'S SIGNATURE

YOUR NAME

DATE

PHOTOGRAPHIC | VIDEO CONTENT

- I hereby grant consent to photographs being taken BEFORE, DURING and AFTER my CoolJet procedure. I agree to these being stored with my case file.
- I hereby give additional consent for my before, during, after & healed photographs to be used for advertising & social media purposes.

CLIENT SIGNATURE

PREVIOUS TREATMENT HISTORY

Have you received any skin tightening treatment before? Yes No

If YES, please answer the following questions:

What procedure(s) did you receive?

Were you happy with the results?

Yes No

If NO, please explain the reason why:

MEDICAL HISTORY, CONDITIONS, LIFESTYLE QUESTIONNAIRE & INFORMED CONSENT:

For your safety and the delivery of a professional treatment, it is absolutely essential that you answer all of the following questions accurately. Please note that answering positively or negatively to many of the questions will not necessarily prevent treatment – it may simply mean your technician will follow specific best practice. If you suffer from any of the conditions listed then it is very important therefore that you notify your specialist so that they can take all the necessary precautions to ensure you receive the best CoolJet treatment and avoid any potential risks to your health or well-being:

General Questions

Are you over the age of 18? ○ Yes ○ No

Are you pregnant and/or nursing (please state if you have been in the last 9 months)? ○ Yes ○ No

Allergies

Do you have any allergies or have you ever experienced allergic reactions to any kinds of medicines, foods, skincare products or products like latex gloves, plasters etc? If so please list: ○ Yes ○ No

Do you have an allergy to penicillin? ○ Yes ○ No

MEDICINES, MEDICAL TREATMENT & MEDICAL CONDITIONS

Have had a hysterectomy in the last 6 months or do you intend to have one in the next 12weeks? ○ Yes ○ No

Have you suffered with any form of diagnosed hormone imbalance in the last 9 months? If so, is it now under control? ○ Yes ○ No

Are you currently undergoing any medical treatment and/ or have you received any medical treatment within the last 6 months? If so, please list: ○ Yes ○ No

Are you currently taking any medication or supplements? If so, please list what you are taking and for what condition. This should include any remedies that you are buying over the counter as well as any prescribed and/ or herbal medicines: ○ Yes ○ No

Do you knowingly suffer from any infectious diseases or any other acute or chronic diseases? If so, please list: ○ Yes ○ No

MEDICINES, MEDICAL TREATMENT & MEDICAL CONDITIONS

Do you suffer from uncontrolled, high or low blood pressure? Do you have any other kind of circulatory issues or deficiencies including Ischemic Tissue and Thrombosis? ○ Yes ○ No

Do you suffer from epilepsy, dizziness, fainting attacks or any other seizure related condition? If so please list: ○ Yes ○ No

Are you taking any anti-coagulant (blood thinning medications) such as Warfarin, Apixaban, Dabigatran, Edoxaban and Rivaroxaban? ○ Yes ○ No

Do you suffer from an auto-immune disease such as Lupus, MS, Scleroderma, Shingles, Psoriasis etc.? If so, please list: ○ Yes ○ No

Do you suffer from diabetes? If so, please state if controlled: ○ Yes ○ No

Do you have any respiratory problems such as Asthma or pulmonary problems like Emphysema, COPD or Bronchitis? If so, please list: ○ Yes ○ No

Do you have any heart problems or conditions? ○ Yes ○ No

- Do you have angina? ○ Yes ○ No
- Do you have a pacemaker? ○ Yes ○ No
- Do you have any other cardiovascular condition? ○ Yes ○ No

Do you suffer from Haemophilia or any other type of blood disorder such as Anaemia, Thalassemia, Polycythemia, Leukaemia, Lymphoma, MDS, Myeloma and Thrombocythemia? If so please list: ○ Yes ○ No

Do you suffer from kidney and/or liver disease? ○ Yes ○ No

Do you have any history of malignant cancer? If yes, have you had any radiation or chemotheraphy treatment and, if so, when? ○ Yes ○ No

Have you ever had a organ transplant? ○ Yes ○ No

Do you suffer from HIV / AIDS? ○ Yes ○ No

Do you suffer from Hepatitis? ○ Yes ○ No

Do you suffer from Herpes Simplex Virus (commonly referred to as cold sores)? ○ Yes ○ No

Do you have any prosthetic implants or any plates or pins in the area being treated by CoolJet? ○ Yes ○ No

RECENT COSMETIC TREATMENTS

Do you have, or are you planning to have anything like botox, fillers, laser treatment, chemical peels, micro- needling or cosmetic surgery in the near future? Have you had any in the last 3 months? If so please list: Yes No

Have you ever had any recent Permanent Make Up (PMU) or cosmetic treatment? If so when and did you experience any problems healing? Yes No

OPTICAL

Are you currently wearing contact lenses? Yes No

Are you currently wearing eyelash extensions? Yes No

Have you had Laser Eye Surgery in the last 3 months? Yes No

Do you have any major visual impairment? Yes No

Do you currently have a corneal abrasion or retinal detachment? Yes No

Do you suffer from Glaucoma, Cataracts, Dry Eye, Styes/Conjunctivitis or Frequent Eye Infections? Yes No

LIFESTYLE QUESTIONS

Have you been actively sunbathing recently (if yes please elaborate)? Yes No

Do you have any imminent holiday plans in the sun? Yes No

Are you in good physical and mental health? Yes No

Are you currently under the influence of alcohol or drugs? Yes No

Do you suffer with body dysmorphia? Yes No

Do you feel fit, well and informed enough to have the CoolJet procedure today? Yes No

Is there any other ailment or reason you feel we should know about which could prevent us from delivering your CoolJet treatment? If so please state: Yes No

CLINICIAN NOTES

Client Expectations

Tip used

Round Rectangle

Passes and Intensity

Pulse:

Continuous:

Products used before treatment

Treatment Course Recommendations

Frequency per week

Total Treatments

Cost of Course

Products used post treatment

Aftercare Recommended

Aftercare form given to client Yes No

List Extra Notes

CLIENT STATEMENT

I am happy with the results obtained from the course of CoolJet treatments. My expectations have been met and understand further treatment may be necessary due to biological ageing and lifestyle factors that have been discussed with me by my clinician.

CLIENT'S NAME

TECHNICIAN'S NAME

DATE

DATE

SIGNATURE

SIGNATURE