SHIBUI
COSMETICS

CLIENT RECORD & CONSENT FORM

Nurse Led. Precision. Natural Results.

Emma
NURSE PRACTITIONER
SPMU ARTIST

RECORD CARD

Clients name:

Address:

Postcode:

Phone number:

Moblie number:

Email:

STRICTLY PRIVATE AND CONFIDENTIAL

TO BE FILLED IN BY THE CLIENT

Full Name:

Address:

Postcode:

Tel No: Mobile: Age:

Email:

DOB: Occupation:

Preferred method of contact:

TODAY'S PROCEDURE	☐ BROWS	☐ LIPS
AGREED PRICE:	£	

CLINICAL PHOTOGRAPHY

I agree to photographs being taken before, during and after my procedures, which will be kept in my case file, or used only with written agreement for promotional purposes.

☐ I consent to clinical photographs for my confidential treatment record.

☐ I separately consent to identifiable photographs being used for promotional/marketing purposes.

☐ I do not consent to promotional/marketing use of my photographs.

CLIENT CONFIRMATION BEFORE TREATMENT

☐ I confirm the information I provide in this form is complete and accurate to the best of my knowledge.

☐ I understand I must tell the practitioner about changes to my health, medication, pregnancy/breastfeeding status, allergies, skin condition or recent procedures before treatment.

☐ I understand the practitioner may postpone, modify or refuse treatment where they consider it unsafe, unsuitable or outside their competence.

☐ I have had the opportunity to ask questions and understand that signing this form does not remove my statutory rights.

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PATCH TESTING FOR ALLERGIES

PATIENT TEST / WAIVER

PLEASE TICK [✓] AS APPROPRIATE

I chose to waiver my option to an allergy test and wish to proceed with the treatment: ☐ Yes

	YES	NO
I understand the skin can determine within 24hrs if I will have a reaction to the products, but that it is inconclusive regarding whether I will have an allergic reaction at any time in the future.	☐	☐
I have undergone or been offered an allergy test prior to my initial treatment and thereby release the technician from any liability to an allergic reaction to applied or other products used after the procedure, or at a later date.	☐	☐

TITANIUM DIOXIDE

Titanium dioxide is a clear ingredient in our pigments and is not always visible in the skin, even though it may be present. Some cosmetic lasers will permanently alter the colour of titanium dioxide, therefore, it is vital that you inform your laser specialist where your micro pigmentation procedure is. Your latest specialist will then take steps to ensure adverse reactions.

NICKEL

I understand that there are traces of nickel in some of the needles and pigments. This may affect me if I'm allergic to nickel. In this case, a patch test is strongly recommended.

I HAVE READ AND UNDERSTOOD THIS SECTION (Please TICK [✓] as appropriate) ☐

MATERIAL RISKS & EXPECTED HEALING

	YES	NO
Temporary redness, swelling, tenderness, bruising, dryness, flaking, itching or minor bleeding may occur.	☐	☐
Pigment may heal lighter, darker, warmer, cooler, uneven or patchy; colour retention varies between individuals.	☐	☐
More than one session may be required. Perfect symmetry and exact colour matching cannot be guaranteed.	☐	☐
Allergic or sensitivity reactions, infection, scarring, pigment migration, granuloma or other inflammatory reaction are uncommon but possible.	☐	☐
Cold sores may reactivate following lip treatment in susceptible clients.	☐	☐
Eyeliner treatment may cause temporary watering, swelling or irritation; contact lenses may need to be removed.	☐	☐
Future laser, MRI/CAT imaging, peels, injectables, surgery, sun exposure, medication and skin changes may affect the appearance of pigment.	☐	☐

☐ I understand these are recognised risks/limitations of SPMU and that an undesirable outcome does not by itself mean the treatment was performed negligently.

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TERMS OF YOUR TREATMENT

PLEASE CHOOSE 'YES' IF YOU AGREE, OR 'NO' IF YOU DISAGREE

Your specialist will check through and ensure you understand and accept these terms.

	YES	NO	PRACTITIONER NOTES
I understand that Semi Permanent Make Up (SPMU) is a process with healing variables, therefore, healed colour cannot be guaranteed.	☐	☐	
I understand that SPMU is a multi- treatment process with colour being implanted slowly and carefully over a period of time and layering process.	☐	☐	
My chosen colour will look much darker when initially implanted but should exfoliate and lighten within 7 /14 days.	☐	☐	
I understand that additional work cannot be undertaken within 4-8 weeks of the first appointment, in order to allow the skin to fully heal.	☐	☐	
I understand that all colours will fade and alter with time. To keep fresh appearance, a re-touch procedure will be required every 6 -12 months. Fade is dependent on age, skin type, medication, colour chosen and sun exposure.	☐	☐	
I agree that my specialist will use a treatment plan to keep a log of the colours we have chosen, along with my pre and post treatment photographs. This information will be held securely in my confidential file.	☐	☐	
I understand that after each treatment, the treated area may swell or show redness and, in some cases, bruising. My specialist will recommend how to take care of this. I may experience some discomfort but my specialist will reassure me throughout and will endeavour to me feel comfortable.	☐	☐	
I understand that if I have an MRI or CAT scan, I must let the radiologist know that I have had a SPMU procedure. I may experience a slight tingling in that area.	☐	☐	
I have been given aftercare instructions and I understand that I must adhere strictly to these instructions.	☐	☐	
I am aware that any sun exposure, future skin altering procedures, such as plastic surgery, peels, implants, and /or injectables, may alter the appearance of my procedure. My technician has discussed likely outcomes with me and recommended a treatment plan, prior to any work being agreed and undertaken.	☐	☐	

DESIGN, COLOUR & TREATMENT APPROVAL

☐ The proposed shape/design has been shown to me before pigment implantation and I approve it.

☐ The proposed pigment colour has been discussed with me and I approve the selection.

☐ I understand natural facial asymmetry and skin characteristics can affect the healed result.

☐ I understand the practitioner may stop the procedure if there is unexpected bleeding, swelling, skin reaction, equipment/product concern, client distress, or any other safety concern.

Client initials confirming design/colour approval: _____ Practitioner initials: _____

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TO COMPLY WITH THE TATTOOING ACT

SECTION 1 - PLEASE SELECT YES OR NO

	YES	NO
Are you over 18?	☐	☐
Are you pregnant or breastfeeding?	☐	☐
Do you feel fit and well to have this procedure?	☐	☐

SECTION 2

	YES	NO
Do you have any allergies or has any allergic reactions to medicine or products eg. Latex, plasters ,nickel etc.?	☐	☐
Have you or are you having any injectable or fillers or chemical peels?	☐	☐
Have you any imminent holiday plans?	☐	☐
Have you any keloid scarring?	☐	☐
Do you suffer from epilepsy and had a seizure in the past 2 years?	☐	☐
Do you suffer from haemophilia?	☐	☐
Do you knowingly have any infectious diseases or mitral valve prolapse?	☐	☐
Do you knowingly have hepatitis?	☐	☐
Do you suffer from shingles ?	☐	☐
Do you suffer from cold sores, fevers, blisters or skin disorders such as psoriasis or Eczema,Acne?	☐	☐
Do you have diabetes?	☐	☐
Do you have any respiratory problems?	☐	☐
Do you have problems with wound healing?	☐	☐
Do you take blood thinners or anti-inflammatory ?	☐	☐
Do you take Antabuse?	☐	☐
Do you take roaccutane ?	☐	☐
Do you have high or low blood pressure?	☐	☐
Do you wear contact lenses/ suffer from glaucoma?	☐	☐
Are you currently taking any medication?	☐	☐
Are you 5 weeks pre or post radiology/chemotherapy treatment? (if yes medical consent must be given)	☐	☐
Are you allergic to local anaesthetic?	☐	☐

If answered yes to any of the above, please give details:

MEDICATION / CONDITION DETAILS & PRACTITIONER DECISION

Relevant medication/condition: _____

Medical advice/clearance requested? ☐ YES ☐ NO If yes, details/date: _____

Decision: ☐ PROCEED ☐ MODIFY TREATMENT ☐ POSTPONE ☐ DECLINE Reason: _____

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CLIENTS DECLARATION

TO BE COMPLETED PRIOR TO COMMENCING TREATMENT

Is this the first procedure for this treatment?	☐ YES ☐ NO
Please state were and when last procedure was carried out:	
Which clinic previous treatment was carried out:	
Date of treatment (approximate):	
Were you happy with the procedure?	☐ YES ☐ NO
Please give reason:	
Are you a Model for Trainee?	☐ YES ☐ NO Date:

I understand the importance of providing an accurate and complete medical history and that withholding any medical conditions may be detrimental to my health and outcome of the procedure.

FOR MODELS HAVING PROCEDURE DONE BY TRAINEES

☐ I am aware of all the above, I also understand this procedure is being carried out by a trainee and not a trained specialist but with the guidance of a specialist technician/trainer. I understand that there are no guarantees as to the success of longevity of my treatment.

PRIVACY & HEALTH INFORMATION

Shibui Cosmetics needs to record information relevant to treatment, including medical and health information. Health information is special-category personal data. The client should be given Shibui Cosmetics' privacy information explaining the controller identity, purposes, lawful bases/conditions, retention, recipients and data rights.

☐ Explicit consent where relied upon: I expressly consent to Shibui Cosmetics processing the health information I provide for the purpose of assessing treatment suitability, providing SPMU treatment, aftercare and maintaining my treatment record. I understand that data-protection consent can be withdrawn, although this does not affect processing already carried out and some records may need to be retained under another lawful basis.

Privacy notice version/date provided to client: _____ Method: ☐ Paper ☐ Email ☐ Other _____

FINAL INFORMED CONSENT

☐ I have read and understood this form, including the risks, limitations, healing process and aftercare requirements.

☐ I have disclosed relevant medical information and have had an opportunity to ask questions.

☐ I understand there are no guarantees as to the success or longevity of my treatment.

☐ I accept these terms and hereby give my written consent for a trained specialist to carry out the course of treatment of my choice.

I hereby give consent for my personal details to be held for up to 10 years.

Client Signature:	Technician Signature:
Print name:	Print name:
Date / time:	Date / time:

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TREATMENT PLAN

A SEPARATE TREATMENT PLAN NEEDS TO BE USED FOR EVERY PROCEDURE

Attach photographs here of before, mark up and after procedure.

Describe / notes for the procedure carried out

DATE:	COLOURS USED:	LOT/EXPIRY:
DATE:	NEEDLES USED:	LOT/EXPIRY:

Pain, tolerance level:
(1= No pain 10=Very painful) (1= No pain 10=Very painful)

Photographic evidence: ☐ PRE ☐ POST

How many further visits needed:

Where there other people present, if so who:

PROCEDURE SAFETY RECORD

Treatment area: _____ Anaesthetic/product used: _____ Batch/expiry: _____

Skin integrity before treatment: ☐ Intact ☐ Concern noted: _____ Gloves/PPE used: ☐ YES

Single-use needle/cartridge opened for this client: ☐ YES Sharps disposed of appropriately: ☐ YES

Unexpected event/adverse reaction during treatment: ☐ NO ☐ YES, details: _____

Action taken / advice given: _____

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TO BE COMPLETED AFTER TREATMENT HAS BEEN CARRIED OUT

Date:

Does the client have any immediate questions ☐ YES ☐ NO

If yes please state:

Technicians advice on the above

Next visit advised/ required: 4-6 weeks 6-8 weeks 8+ weeks Annual

PLEASE NOTE

Every clients skin is unique and colours need to be refreshed potentially from 6 months (for lighter colours) and 12 months (for the darker colours). Clients will experience slight colour change and patchy areas during the months leading up to a colour boost. One colour boost may not be enough for clients who want the dramatic look, therefore the client will usually need a full two procedures 4-6 weeks apart to retain this look. Clients who choose not to take this advice is their own choice and no fault of the technician.

AFTERCARE

Aftercare received ☐ YES ☐ NO

Written:

Client signature: Date:

WHEN TO SEEK HELP

The client should contact the practitioner promptly if they have concerns about healing. Urgent medical advice should be sought for severe or rapidly worsening swelling, spreading redness, increasing heat/pain, pus, fever, breathing difficulty, facial/throat swelling, visual disturbance or other serious symptoms.

Practitioner contact / out-of-hours instructions: _____

MARKETING

From time to time we would like to contact you with details of our special offers and other products and services that we provide. We use emails and SMS for our marketing if you consent for us to contact you for this purpose please tick to say how you would prefer to be contacted.

☐ SMS ☐ EMAIL ☐ PREFER NOT TO BE CONTACTED

Marketing consent is optional and can be withdrawn at any time using the contact method in the privacy notice.

PRACTITIONER DECLARATION

☐ I reviewed the client's medical history and responses and considered suitability for treatment.

☐ I discussed the procedure, material risks, expected healing, alternatives/option not to proceed, and aftercare.

☐ I answered the client's questions and obtained consent before commencing treatment.

☐ I recorded products, colours, needles/cartridges and relevant batch/expiry information.

Practitioner signature: _____ Date/time: _____