Coolsculpting Treatment Form

Date: _____ dd / mm / yyyy Therapist name: _____

Treatment Area

Body area treated: _____ Number of treatments advised by medical practitioner: _____

Weight: _____

STANDARD PROCEDURES:

Standard procedures:

- [ ] Clinical photographs taken
- [ ] Consent procedure completed
- [ ] Double sterilisation of area to be treated
- [ ] Equipment sterilised and correctly applied
- [ ] No adverse reactions observed post treatment
- [ ] Aftercare sent
- [ ] Patient weight taken and recoded
- [ ] Gloves donned
- [ ] Pre treatment wipe applied correctly to the area to be treated
- [ ] Skin intact pre treatment
- [ ] Client satisfied post procedure
- [ ] Follow up appointment booked

PHOTOS

- [ ] Pre-treatment photos taken

COOLMINI® APPLICATOR

- [ ] Checked

COOLADVANTAGETM APPLICATOR:

CoolAdvantageTM Applicator:

- [ ] CoolCurve+ AdvantageTM Contour
- [ ] CoolCore AdvantageTM Contour
- [ ] CoolFit AdvantageTM Contour

COOLADVANTAGE PLUSTM APPLICATOR:

CoolAdvantage PlusTM Applicator:

- [ ] CoolCurve+ Advantage Plus Contour
- [ ] CoolCore Advantage Plus Contour

Where?

Treatment comments/observations

Medical practitioner has assesed the patient and has advised me to use the following settings. The number of treatments has been determined by medical practitioner after the assesment with the patient.

MASSAGE

Massage

- [ ] 2-minute post-treatment massage
- [ ] Failed treatment

Follow up comments/observations

OTHER

Other

- [ ] Post-treatment photos taken
- [ ] 48-hour post-treatment phone call

Any changes in medical history?

- ◯ No
- ◯ Yes