Cancel

Cosmetic Injectables Treatment Record

What's your name?

First name First name

Last name Last name

Email address (optional)

SMS Number (+64) (optional)

Date of birth (optional)

Tap here to select a date

General

Date of treatment

Tap here to select a date

Name of consultant/practitioner Answer

Patient attended for Answer

Medical history checked

- ○ Yes
- ○ No

Pregnant/lactating (optional)

- ○ Yes
- ○ No

Contraindications (optional)

- ○ Yes
- ○ No

Signed consent form on file

- ○ Yes
- ○ No

Treatment

Pre treatment photo

First injectable treatment (optional) Answer

Date of last treatment (optional) Answer

Volume/units used Answer

Tx anaesthesia (optional) Answer

Brand Answer

Lot # Answer

Injection sites

General comments (optional)

Answer

Complete