



CLINICIAN NAME : \_\_\_\_\_ DATE OF TREATMENT : \_\_\_\_\_

PATIENT NAME : \_\_\_\_\_ AGE : \_\_\_\_\_ SEX *Male* ☐ *Female* ☐

**TREATMENT INFORMATION**

1. Pre-treatment photos taken ☐

2. Treatment Tip Information : *I Tip 0.25* ☐ *F Tip 3.0* ☐ *V Tip 4.0* ☐ *S Tip 16.0* ☐

3. Treatment Start Time : \_\_\_\_\_ Treatment End Time : \_\_\_\_\_

4. Treatment areas and treatment parameters :



MAIN PASSES		VECTORS		ADDITIONAL TREATMENT ZONES	
Number of Shots		Number of Shots		Number of Shots	
Number of Passes		Number of Passes		Number of Passes	
Used Tips		Used Tips		Used Tips	
Parameters		Parameters		Parameters	

5. Total number of shots delivered : \_\_\_\_\_

6. Rate erythema immediately post treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

7. Rate edema immediately post treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

8. Rate patient discomfort during treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

**PATIENT FOLLOW-UPS**

FOLLOW-UP DATE : \_\_\_\_\_

CLINICIAN'S COMMENTS : \_\_\_\_\_

PROVIDER'S SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_



CLINICIAN NAME : \_\_\_\_\_ DATE OF TREATMENT : \_\_\_\_\_

PATIENT NAME : \_\_\_\_\_ AGE : \_\_\_\_\_ SEX *Male* ☐ *Female* ☐

### TREATMENT INFORMATION

1. Pre-treatment photos taken ☐

2. Treatment Tip Information : *I Tip 0.25* ☐ *F Tip 3.0* ☐ *V Tip 4.0* ☐ *S Tip 16.0* ☐

3. Treatment Start Time : \_\_\_\_\_ Treatment End Time : \_\_\_\_\_

4. Treatment areas and treatment parameters :



RIGHT EYE		LEFT EYE	
Number of Shots		Number of Shots	
Number of Passes		Number of Passes	
Used Tips		Used Tips	
Parameters		Parameters	

5. Total number of shots delivered : \_\_\_\_\_

6. Rate erythema immediately post treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

7. Rate edema immediately post treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

8. Rate patient discomfort during treatment : *None* ☐ *Low* ☐ *Moderate* ☐ *Severe* ☐

### PATIENT FOLLOW-UPS

FOLLOW-UP DATE : \_\_\_\_\_

CLINICIAN'S COMMENTS : \_\_\_\_\_

PROVIDER'S SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_



CLINICIAN NAME : \_\_\_\_\_ DATE OF TREATMENT : \_\_\_\_\_

PATIENT NAME : \_\_\_\_\_ AGE : \_\_\_\_\_ SEX *Male* ☐ *Female* ☐

### TREATMENT INFORMATION

1. Pre-treatment photos taken ☐ 2. Pre-treatment weight ☐ Kg

Pre-treatment measurement ☐ *Inch* ☐ *Areas*

3. Treatment Tip Information : *I Tip 0.25* ☐ *F Tip 3.0* ☐ *V Tip 4.0* ☐ *S Tip 16.0* ☐

4. Treatment Start Time : \_\_\_\_\_ Treatment End Time : \_\_\_\_\_

### 5. Treatment areas and treatment parameters :

☐ *Decolletage* \_\_\_\_\_

☐ *Upper Arm* \_\_\_\_\_

☐ *Abdomen* \_\_\_\_\_

☐ *Upper Thighs* \_\_\_\_\_

☐ *Lower Thighs* \_\_\_\_\_

☐ *Above the Knee* \_\_\_\_\_

☐ *Upper Arm* \_\_\_\_\_

☐ *Buttocks* \_\_\_\_\_

☐ *Upper Thighs* \_\_\_\_\_

☐ *Lower Thighs* \_\_\_\_\_

The image shows two full-body photographs of a female patient standing against a white background. She is wearing a white, form-fitting leotard. The left image is a front view, and the right image is a back view. To the left of the front view and to the right of the back view are checkboxes with labels for various body areas: Decolletage, Upper Arm, Abdomen, Upper Thighs, Lower Thighs, and Above the Knee (for the front view); and Upper Arm, Buttocks, Upper Thighs, and Lower Thighs (for the back view). Lines connect the checkboxes to the corresponding areas on the patient's body.



TREATMENT AREAS		TREATMENT AREAS	
Number of Shots		Number of Shots	
Number of Passes		Number of Passes	
Used Tips		Used Tips	
Parameters		Parameters	

TREATMENT AREAS		TREATMENT AREAS	
Number of Shots		Number of Shots	
Number of Passes		Number of Passes	
Used Tips		Used Tips	
Parameters		Parameters	

5. Total number of shots delivered : \_\_\_\_\_

6. Rate erythema immediately post treatment :      None ☐      Low ☐      Moderate ☐      Severe ☐

7. Rate edema immediately post treatment :      None ☐      Low ☐      Moderate ☐      Severe ☐

8. Rate patient discomfort during treatment :      None ☐      Low ☐      Moderate ☐      Severe ☐

## PATIENT FOLLOW-UPS

FOLLOW-UP DATE : \_\_\_\_\_

CLINICIAN'S COMMENTS :  
 \_\_\_\_\_  
 \_\_\_\_\_

PROVIDER'S SIGNATURE : \_\_\_\_\_

DATE : \_\_\_\_\_