Ultherapy® Consult Record

THIS SECTION FOR HEALTH-CARE PROFESSIONAL USE ONLY

Treatment checklist

Pre-treatment photos taken: ☐YES ☐NO
Procedure reviewed with patient: ☐YES ☐NO
Patient questions answered: ☐YES ☐NO
Informed Consent signed: ☐YES ☐NO
Photo Consent signed: ☐YES ☐NO
Ultherapy™ treatment date: _____
Pre-Medication Order: _____
Ultherapy™ Treatment Record from System printed: ☐YES ☐NO
Ultherapy™ Patient Record completed: ☐YES ☐NO
"What to Expect" pamphlet instruction given to patient: ☐YES ☐NO

Follow up checklist

Aesthetic care plan discussed: _____

_____

_____

3 month follow-up appointment scheduled: _____

1st follow-up visit date: _____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90

2nd follow-up visit date: _____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90

Clinical and treatment notes:

_____

_____

_____

_____

_____

Ultherapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

*Ultherapy® is contraindicated for use

** Ultherapy® is not recommended for use directly over this

*** Ultherapy® has not been evaluated for use in this scenario