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CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, sacroiliac conditions, sexual dysfunction, and/or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the perineal region, including the vagina and/or rectum externally and /or internally. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar and nerve mobility and tenderness, as well as the function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization, breathing/relaxation techniques, and educational instruction. Potential risks: I may experience a temporary increase in my current level of pain or discomfort, emotional distress, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist. Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me. Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. Cooperation with treatment: I understand that in order for therapy to be effective, I must attend all of my scheduled therapy appointments, unless there are unusual circumstances that prevent me from doing so. I agree to cooperate with and follow the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

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CONSENT ACKNOWLEDGMENT AND WAIVER

I, _____, give my consent for

_____("Therapist") to perform a vaginal and/or rectal examination for the purposes of evaluating my condition and providing therapeutic treatment. I hereby acknowledge the following by initialing below: _____ I am 18 years or older;

_____ I have been examined by a physician for this condition and assured that there is no underlying medical cause for this condition, beyond what a physical therapist can be reasonably expected to treat;

_____ This examination and treatment involves extremely sensitive touching, both internally and externally;

_____ I understand that I can terminate the procedure at any time; _____ I understand that I am responsible for informing the examiner if I experience any unusual symptoms or any type of discomfort during the procedure; _____ I understand that, given the nature of the treatment, I have the option of having a second person present in the room during treatment. This person could be a family member, friend, or clinic staff member.

Please indicate your preference with your initials.

_____ Yes, I would like to have an additional person present.

_____ Yes, I would like to have another clinic staff member present.

_____ No, I would not like an additional person present.

*Please inform the therapist if you are pregnant, have an infection of any kind, have an IUD or other implants, a sexually transmitted disease, are less than 6 weeks post-partum or post- surgery, have severe pelvic pain or have sensitivity to lubricant, vaginal creams, or latex, prior to the pelvic floor assessment.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____