



CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

Informed consent for 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 functions, 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, scar mobility, reflexes, muscle tone, length, strength, and endurance.

Chaperone policy: I understand that I have the option of bringing a spouse, family member, or friend with me to my visits if it makes me feel more comfortable having a second person in the room with me. Otherwise, I understand that I can decline this option. If I am 14 years old or younger, I agree to always have my parent/ guardian attend my visits with me.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback, electrical stimulation, ultrasound, stretching and strengthening exercises, internal and/or external soft tissue and/or joint mobilization, relaxation techniques, and educational instruction. Treatment may also include the use of vaginal dilators and/or vaginal weights.

Your therapist will let you know if they believe that sEMG biofeedback or vaginal dilators will be necessary to complete your care. If you should need internal sEMG biofeedback, there is a one-time \$55.00 charge to cover that cost. Should you need vaginal dilators for your treatment, your therapist will assist you in ordering them or you may purchase one from the clinic.

Potential risks: I may experience an 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 may gain a greater knowledge about managing my condition and the resources available to me.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out 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

*****If you are pregnant, have infections of any kind, an IUD or other implants, severe pelvic pain, a sexually communicable disease, sensitivity to vaginal lubricants or latex, or are less than 6 weeks postpartum or post-surgery, please inform the therapist prior to pelvic floor assessment.*****

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment. I understand that I may withdraw at any time.

Patient Signature: _____ **Date:** _____

Parent/ Guardian Signature (if applicable): _____

Therapist Signature: _____