FYZICAL Therapy & Balance Centers

INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to a pelvic health therapist for an evaluation and treatment of pelvic floor dysfunction and related impairments of the pelvic girdle. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist(s) or their trained assistant(s) to perform an internal pelvic floor muscle and pelvic girdle examination. This examination will include, but is not limited to assessment of skin condition, reflexes, muscle tone, length, strength, and endurance, scar mobility, and function of the pelvic floor region. It may be necessary to perform an internal pelvic floor evaluation by inserting a gloved finger(s) into the perineal region including the vagina and/or rectum.

Treatment of the pelvic floor region and/or pelvic girdle may include, but is not limited to the following: observation, palpation, use of vaginal weights and other tools, vaginal and/or rectal sensors for biofeedback and/or electrical stimulation, heat, ice/cryotherapy, stretching and strengthening exercises, soft tissue and/or joint mobilization and education instruction.

I understand that I will have the opportunity to give/revoke my consent at each treatment session. Verbal consent will continuously be obtained throughout each session and I am always in control of my own body and what is performed during sessions at physical therapy. I understand that I may request further patient education at any time during my therapy plan of care.

I understand that I have the option to have a second person in the room for the pelvic floor evaluation and treatment (as described above). The second person present, besides myself and the treating/evaluating therapist, can be a friend, family member, or clinic staff member. Please indicate your preference with your initial below:

___ YES I want a second person present during the pelvic floor evaluation and treatment.
___ NO I do not want a second person present during the pelvic floor evaluation and treatment.
___ I would like to discuss my options with my treating therapist prior to consenting.

Potential Risks: I acknowledge that a full pelvic floor evaluation and/or pelvic floor treatment may increase my current level of pain or discomfort, or an aggravation of my existing injury/symptoms. This discomfort is usually temporary. If it does not subside in 1-3 days, I agree to contact my therapist and/or physician.

Potential Benefits: A full pelvic floor evaluation and/or pelvic floor treatment may improve my symptoms and increase my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance of my pelvic girdle muscles. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition/impairments and will be more aware of the resources available to me.

No Warranty: I understand that the therapist(s) cannot make any promises or guarantees regarding a cure for improvement of my condition. I understand that my therapist(s) will share their opinion with me regarding potential results of physical therapy and will discuss all treatment options before I consent to treatment based on subjective and objective examination findings.

I have informed my therapist(s) of any condition** that would limit my ability to have an evaluation or treatment performed to the perineal/pelvic region including internal palpation of the vagina and/or rectum. I hereby request and consent to the evaluation and treatment to be provided.

By signing below, I agree that I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT, and that I consent to the evaluation and treatment of my pelvic floor/pelvic

girdle. Below I will list any concerns, requests, or stipulations necessary to proceed with evaluation and/or treatment that I have consented to:

_____

_____

_____

Patient Name (please print) _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

If you are or may be pregnant, have an infection within or near the pelvic region, have an IUD or other implants, have a secually communicable disease, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity or allergies to lubricant, vaginal creams or latex, please inform the therapist(s) prior to the pelvic floor evaluation and treatment session.