PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred for evaluation and/or treatment for pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to : urinary incontinence or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain 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 by observing and/or touching the perineal region including the vagina/genitals and/or rectum. This evaluation will assess skin conditions, reflexes, muscles tone, length, strength and endurance, scar mobility and function of the pelvic floor region. This evaluation may include vaginal or rectal sensors for muscle biofeedback.

I understand that in order for therapy to be effective, I must come to appointments as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me or for my child. If I or my child has any difficulty with any part of my treatment program, I will discuss it with my therapist.

☐ The purpose, risks and benefits of this evaluation have been explained to me and I understand the purpose, risks and benefits.

☐ I understand that I can terminate any procedure at any time with my therapist; however termination of procedures may lead to a discontinuation of care and/or an incomplete evaluation/and or therapy for services I am scheduled for.

☐ I understand that I am responsible for **immediately** telling the examiner and/or therapist if I or my child is having any discomfort or unusual symptoms during the evaluation of myself or my child.

☐ I have the option of having a second person present in the room during any procedure and I :

_____ ◯ Choose to HAVE another person in the room during any procedure

_____ ◯ Choose NOT to have another person in the room during any procedure

Date:_____ **Patient Name** (Print please)_____

Patient Signature or Legal Guardian_____

Witness Signature_____ Date_____