**CONSENT FOR EVALUATION AND TREATMENT**

You have been referred for evaluation and/or treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to: urinary or fecal incontinence (leakage), pelvic organ prolapse, constipation, pain in the pelvic region, scarring after childbirth or surgery, and sexual dysfunction or pain with intercourse.

To evaluate your condition, it may be necessary to have a physical therapist perform a pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region, including the vagina and/or rectum externally and/or internally. The examination may include assessment of:

* Skin condition
* Reflexes and sensation
* Muscle function, length, strength (endurance & power), and areas of tenderness
* Nerve or scar mobility and tenderness
* Position of pelvic organs in relation to pelvic floor muscles

Treatment may include, but not be limited to:

* Education/instruction
* Observation
* Palpation
* Stretching and strengthening exercises
* Relaxation techniques
* Soft tissue and/or joint mobilization
* The use of vaginal or rectal sensors for biofeedback and/or electrical stimulation
* The use of ultrasound, heat, or cold packs

**Potential risks** of this evaluation is equal to that of a gynecological exam.

* Pain or discomfort in the perineal, vaginal, or rectal regions. Severe pain is not expected and should be communicated to the therapist immediately. Replication of your pain may aid in identifying your impairment.
* Emotional response. If this occurs you are in control and can stop the examination at any time.
* Increased parasympathetic stimulation or response (nausea, sweating, cold clammy feeling)
* Feeling of fullness or pressure in the rectum
* Urge to urinate or defecate following or during the procedure
* Small risk of infection similar to intercourse or gynecological exam

**Potential benefits** of this examination may include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You should gain a greater knowledge about managing your condition and the resources available to you.

**Alternatives** to an internal examination:

* Education and/or instruction alone
* Clothed external palpation of pelvic/perineal region
* Unclothed external visualization of the pelvic/perineal region
* Unclothed external palpation of the pelvic/perineal region
* External biofeedback examination
* No examination

**Please Initial and Sign Below:**

**\_\_\_\_\_\_1.** The purpose, techniques, benefits, risks, and alternatives to the examination have been presented to me.

**\_\_\_\_\_\_2**. I understand that I can terminate the procedure at any time.

**\_\_\_\_\_\_3.** I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure

**\_\_\_\_\_\_4.** I understand that I have the option of having a second person in the room during the procedure. If I elect to do so, I understand that I am responsible for providing that person to be available during the examination and/or treatment.

**\_\_\_\_\_\_5.** I give my consent for pelvic floor examination and treatment.

**\_\_\_\_\_\_6.** I authorize the release of my medical records to my physicians/primary care provider or insurance company.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_ (Please Print)

**Patient or Parent/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_