ABLE PHYSICAL THERAPY

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Pelvic Floor Consent For Evaluation and Treatment

I 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 and/or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent low back or sacroiliac pain or pelvic pain conditions.

I understand that to evaluate my condition, it may be necessary initially and periodically, to have my Physical Therapist perform an internal pelvic floor muscle examination. This examination may include observation and /or palpation the perinea! region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, muscle length, muscle strength and endurance, scar mobility and function of the pelvic floor region. This evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vagina /or rectal sensors for biofeedback and /or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and joint mobilization and educational instruction.

I understand that in order for therapy to be effective, I must carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I **will** discuss it with my therapist.

1. The purpose, risks and the benefits of this evaluation and treatment have been explained 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 have any discomfort during the evaluation / treatment.

4. I have the option of having a second person (of my choice and provided by me) present in the room during the procedure and __ choose __ refuse this option.

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date