

**INFORMED CONSENT FOR ASSESSMENT OF PELVIC FLOOR DYSFUNCTIONS**

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to assess muscle strength, length, range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other similar complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation.

I understand that the benefits of the vaginal/rectal assessment will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include, without limitation, education, exercise, stimulation, ultrasound, use of vaginal weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all these treatment procedures to me and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment.

Based on the information I have received from the therapist, I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area.

\_\_\_\_\_  
Patient's Signature & Date

\_\_\_\_\_  
Therapist's Signature & Date

\_\_\_\_\_  
Patient's Legal Representative/Guardian/Parent

\_\_\_\_\_  
Relationship to Patient

\*\*If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to the pelvic floor assessment.

**Physical Therapy**

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**CONDITIONS & CONSENT FOR PHYSICAL THERAPY**

**1. COOPERATION WITH TREATMENT:**

I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstance that prevent me from attending therapy.

I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel or reschedule.

I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.

**2. NO WARRANTY:**

The physical therapy department does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

**3. INFORMED CONSENT TO TREATMENT:**

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The department provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

**Potential Risks**

You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 hours.

**Potential Benefits**

Benefits 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 will have greater knowledge on managing your condition and the resources available to you.

**Alternatives**

All physical therapy treatment options available for your conditions will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

\_\_\_\_\_  
Patient's Signature/Date

\_\_\_\_\_  
Therapist's Signature/Date

\_\_\_\_\_  
Patient's Legal Representative/Guardian/Parent

\_\_\_\_\_  
Relationship to Patient

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Integrity Rehab