NEWBURY PARK
PHYSICAL THERAPY

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CONSENT FOR EVALUATION AND TREATMENT OF PELVIC FLOOR DYSFUNCTION

I acknowledge and understand that I have been referred to Newbury Park Physical Therapy for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction includes but is not limited to urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, and vulvar or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform internal pelvic floor muscle examinations. **This examination is performed by observing and palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region.** Such an evaluation and/or treatment could potentially elicit pain or discomfort.

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

I understand that no guarantees have been or can be provided regarding the success of therapy. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and staff of Newbury Park Physical Therapy.

If you consent, you have the option to have a person in the room for the pelvic floor muscle evaluation and treatment. The second person could be a friend, family member, or any other person of your choosing. Please indicate your preference with your initials:

___ YES I want a second person present during the pelvic floor muscle evaluation and treatment.

___ NO I do not want a second person during the pelvic floor muscle evaluation and treatment.

Patient name (Print):_____

Patient Signature:_____ Date:_____