Pelvic Floor Examination Consent Form

I consent to receive treatment from a physical therapist with appropriate training to assess my pelvic floor through internal palpitation (vaginal and/or rectal exam).

I understand that I will have the opportunity to give/revoke my consent at each treatment session, and at any stage of the session.

I understand that I may have a person of my choice accompany me during the evaluation, and that the exam will occur in a clean, private & secure area.

I understand that I will be required to partially disrobe for the exam and that appropriate draping and coverings will be provided.

I will communicate relevant medical history information to the therapist including, but not limited to, medication use, IUDs (or other implants), pre-existing urogenital infection or known sexually communicable diseases.

I confirm that I am not in the first trimester of pregnancy (14 weeks).

I understand that this examination is performed by observing, palpating or inserting a gloved finger into 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 functional activity of the pelvic floor region.

Treatment may include, but is not 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, use of dilators, therapist conducted internal massage and trigger point release, use of self-administered internal massage, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, an aggravation of my existing injury or minor bleeding. These effects are usually temporary; if they do not subside in 1-3 days, I agree to contact my therapist or physician.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I may experience improved continence. I should gain a greater knowledge about managing my condition and the resources available to me.

By signing below I acknowledge that I have read and understood the above information.

Printed Name:
Signature:
Date: