Consent to Pelvic Diaphragm Physical Therapy Examination and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic diaphragm dysfunction. I understand that, in order to evaluate my condition, it may be necessary, initially and periodically, to have my Physical Therapist perform an internal pelvic diaphragm muscle examination. This examination is performed by observing and/or palpating the perineal region, including the vagina and/or rectum. This examination may assess skin condition, reflexes, muscle tone, length, strength, endurance, power, scar mobility, and function of the pelvic diaphragm region. 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, and educational instruction.

I understand that the indication for this examination is pelvic diaphragm dysfunction. This includes, but is not limited to, conditions related to pelvic diaphragm muscle weakness, such as urinary and/or fecal incontinence or pelvic organ prolapse, conditions related to pelvic diaphragm tension syndromes, such as painful bladder syndrome, vulvar pain, sexual pain, and/or menstrual pain or tension from contributing diagnoses such as endometriosis or dysmenorrhea, and/or neurological dysfunctions affecting the pelvic diaphragm, such as pudendal neuralgia, pudendal nerve entrapment, and/or other nerve entrapment syndromes. I understand that the contraindications for this examination are the patient not consenting to this examination, active infection, lack of cognition to understand the procedure and participate in the plan of care, no prior pelvic exam, the patient being pediatric, and/or the clinician not demonstrating competency and/or feeling comfortable with these procedures.

I understand that benefits of treatment may include 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 should gain a greater knowledge about managing my condition and the resources available to me. I understand that potential risks of treatment may include an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my Physical Therapist. I understand that if I do not wish to participate in the Physical Therapy program, I may discuss my medical, surgical, or pharmacological alternatives with my Physical Therapist or treating Physician.

I understand that in order for Physical Therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending Physical Therapy. I agree to cooperate with and carry out the prescriptive movement assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my Physical Therapist. I understand that the Physical Therapist cannot make any promises nor guarantees regarding a cure for or improvement in my condition. I understand that my Physical Therapist will share with me her opinions regarding potential results of Physical Therapy treatment for my condition, and will discuss all treatment options with me before I consent to treatment. I have informed my Physical 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. I have read this consent form, understand the indications, contraindications, benefits, risks, and alternatives involved in my Physical Therapy treatment plan, and agree to fully cooperate and participate in the proposed Physical Therapy interventions in the established plan of care. I understand that I have the right to refuse any of these examination and/or treatment techniques of the pelvic diaphragm at any time. I understand that I am responsible for immediately telling the Physical Therapist if I am having any discomfort or unusual symptoms during the examination and/or would like to request having a second person present in the room when I am being treated. I understand that Navel reserves the right to discontinue services at any time, if, at its discretion, Navel believes the services I am requesting are not appropriate for my condition, or I display inappropriate behavior during a treatment session. If Navel discontinues a session because of any inappropriate behavior on my part, I will not be entitled to a refund.

I understand that I am given the opportunity to bring a friend or family member as an observer to any of my Physical Therapy treatments, and I indicate my choice below:

▢ Chaperone Present

▢ Chaperone Declined

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Patient Name

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Patient Signature Date