# Informed Consent for Assessment of Pelvic Floor Dysfunctions

I understand that if I undertake physical therapy for pelvic floor dyfunction, it will be beneficial and necessary for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to access 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 anal/rectal canal. Pelvic floor dysfunctions include but are not limited to pelvic pain syndromes, urinary incontinence, fecal incontinence , dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis, constipation, pain with urination or defecation, diffuse gluteal pain, organ prolapse, diffuse lower extremity pain, other similar complications. Evaluation of my condition may include observation, direct muscle palpation, soft tissue mobilization, use of vaginal or rectal sensors for biofeedback and/or electrical stimulation.

The benefits and risks of the vaginal/rectal assessment have been 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. **_____(Initials)**

Treatment procedures for pelvic floor dysfunctions include, without limitation, education, exercise, neuromuscular reeducation using biofeedback, neuromuscular reeducation, electrical stimulation, and several manual techniques including massage, myofascial release, strain counter strain, ischemic pressure, joint and soft tissue mobilization. The therapist will explain these treatment procedures to me and I may choose not to participate with all or part of the treatment plan. Risks/side effects may include: muscle or joint soreness, slight muscle pain, referred discomfort to another part of the body, fatigue, temporary discomfort with defecation, walking or activities of daily living. I understand that no guarantees have been or can be provided to me regarding the success of therapy. I understand the risks, benefits and alternatives of the different treatment procedures.

I hereby voluntarily agree to allow my physical therapist to perform both initial and periodic muscle assessments of the pelvic floor via the vagina or anal/rectal canal and to perform muscular treatment techniques of the perineal area. **_____(Initials)**

I **DO____** or **DO NOT_____** want to have an additional person (chaperone) in the room during my sessions. **_____(Initials)**

_____ _____

Patient's Signature & Date | Physical Therapist's Signature & Date

_____ _____

Patient's Legal Representative | Relationship to Patient

**PLEASE NOTE:** 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.