CONSENT FOR EVALUATION AND TREATMENT

I understand that my physician has referred me to physical therapy for evaluation and treatment of pelvic floor dysfunction, and it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum.

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. I understand that I may refuse any part of the treatment plan that I am uncomfortable with.

I understand that at any time I may request to have another person present during the evaluation and treatment.

I hereby request and consent to the evaluation and treatment to be provided by the physical therapist.

Patient Name (please print): ____

Patient Signature: _______________________________________ Date: ____________

Signature of Parent or Guardian (if applicable): ________________________________

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