CORNERSTONE
PHYSICAL THERAPY & BEHAVIORAL HEALTH

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Consent For Evaluation and Treatment of Pelvic Floor Dysfunction

I acknowledge and understand that I have been referred to Cornerstone Physical Therapy Women's Health Program for evaluation and treatment of my pelvic floor dysfunction. Pelvic floor dysfunctions include but are not limited to pelvic floor muscle weakness, pelvic organ prolapse, incontinence, bladder, bowel or sexual dysfunctions, chronic vulvar or pelvic pain, painful scars after childbirth or surgery, persistent sacroiliac or low back pain.

I understand that to evaluate my condition it may be necessary initially and periodically to have my therapist perform an internal pelvic floor muscle assessment. This assessment is performed by observing and palpating the perineal area including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, muscle length, strength and endurance, scar mobility and function of the pelvic floor region. I understand that I can refuse the internal examination at any time. The physical therapist that will be performing the internal assessment has had extensive education and training pertaining to the pelvic floor.

Treatment may include but not be limited to the following: observation, palpation, perineal biofeedback, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I understand that no guarantees have been or can be provided regarding the success of the therapy. I hereby request and consent to the evaluation and treatment to be provided by the therapists, therapy assistants of Cornerstone Physical Therapy Women’s Health Program.

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Name

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date