**CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT**

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. This includes, but is not limited to, urinary or faecal incontinence, difficulty with bowel, bladder, or sexual functions, painful scars after childbirth or surgery, persistent lower back or pelvic pain conditions.

I understand that to evaluation my condition it may be necessary to have my therapist perform an internal pelvic floor muscle examination and or an external ultrasound examination. The internal pelvic floor examination is performed by observing and or palpating the perineal region including the vagina and/or rectum. This is to assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region.

I understand that I can terminate the procedure at any time and I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.

I have the option of having a second person in the room during the procedure.

Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_