Corina Avni Registered Physiotherapist
Special interest in Pelvic Function
Practice Number: 0052205
HPCSA: PT0063541
Room 100 Fairfield Suites, Kingsbury Hospital, Wilderness Rd, Claremont, Cape Town, 7708
Cell: + 27 (0)83 258 2843 corina@pelvicfunction.co.za www.pelvicfunction.com

Consent for Evaluation of Pelvic Floor Muscle Dysfunction

I acknowledge that I have been referred for evaluation and treatment of pelvic floor dysfunction.

Pelvic floor dysfunctions include, but are not limited to, urinary or faecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; pelvic pain conditions.

I understand that to evaluate my condition it is necessary for my physiotherapist, who has been trained in women's / men's health, to perform an external and/or internal pelvic examination per vagina or rectum. This examination will assess skin condition, reflexes, muscle tone, -length, -strength and - endurance, scar mobility, and function of the pelvic floor region and may include vaginal or rectal sensors for muscle biofeedback. The assessment may be curtailed in certain circumstances which might not warrant an extensive assessment (e.g. pelvic pain conditions).

Treatment may include any of the following modalities: observation, palpation, soft tissue techniques, joint mobilization, vaginal or rectal sensors for biofeedback and/or electrical stimulation, stretching and strengthening exercises, relaxation and mindfulness training, use of vaginal weights, ultrasound, heat, cold and educational instruction.

I acknowledge the following:

- I am not aware that I have any infection of the area to be examined ☐
- I am not aware that I am pregnant ☐
- I am not aware that I am allergic to latex ☐
- I haven't had any surgery / pelvic radiation in the last 6 weeks ☐
- The purpose, risks, and benefits of this evaluation have been explained to me ☐
- I understand that I can terminate the procedure at any time ☐
- I understand that I am responsible for telling the examiner immediately if I am having any discomfort or unusual symptoms during the evaluation ☐

I choose the option of having a third person present in the room during the procedure YES/NO

Is there any other information that you wish to disclose to your therapist? ……

……

Name of Patient ……

Signature of patient ……

Signature of Parent or Guardian (if applicable) ……

Name of physiotherapist Corina Avni

Signature of physiotherapist ……

Date …… **Time** …… **Place** ……