Client's NAME	DATE
Client's ADDRESS	Clinician/Operative

Section A

The areas for treatments have been reviewed with me today and I am in agreement. I have been thoroughly advised regarding the objectives of the procedure.

I understand that although these procedures are effective in most cases, no results have been guaranteed.

I acknowledge that imperfections might ensue and that the operative result may not live up to my expectations.

I understand that clinical results may vary based on many variables such as age, lifestyle and current conditions.

I understand that the treatment will involve applying heat to the vulvar and vaginal tissues using radio frequency for therapeutic purposes.

I am aware of the following possible experiences and/or risks associated with the procedure:

- *Discomfort may be experienced during an/or after the treatment*
- *Some mild swelling and/or temporary redness may occur following the procedure.*
- *Potential for transient over-active bladder*
- *Injury to bowel and bladder*
- *Scarring is rare but is a possibility if the skin surface is disrupted*
- *Although uncommon, burns can occur and may require additional care at my own expense.*
- *Infection (urinary tract, vaginal infection) is uncommon but should it occur, treatment with antibiotics and/or surgical intervention may be required. Infection can further increase the risk of scarring. Proper wound care is important in the prevention of infection. If signs of infection such as pain, heat, blisters, or surrounding redness develop, call the office immediately.*

SI ☐ UI ☐ OAB ☐ ISD ☐ DO ☐ LAXITY ☐
AESTHETICS ☐

Section B

I understand this technology does not have any manufacturer declared contraindications, it is advised not to treat patients with the following conditions.

I confirm that none of the following apply to me:

- *Cardiac devices such as AICD's (auxiliary internal cardiac devices such as defibrillators, mechanical valves, pacemakers).*
- *Pregnancy*
- *Active Sexually Transmitted Diseases*
- *Current urinary tract infection*

Section C

I request and authorise _____ or designated person to perform the following procedure utilising temperature controlled radio frequency technology.

Radio frequency treatment of the vulvo-vaginal region:

- ☐ Labia Minora
- ☐ Labia Majora
- ☐ Vagina and Perineum

The nature and effects of the procedure, the risks, the ramifications, complications, as well as alternative methods of treatment have been fully explained to me by the physician or designated operative and I understand them. The benefits of the proposed procedure, along with the probability of success have also been discussed with me. I have been given the opportunity to ask questions and have received satisfactory answers.

I certify that I have read the above authorisation and that I fully understand it.

Signature of Client _____ Date _____

Signature of Operative _____. Date _____