Missoula Osteopathic Clinic, PLLC
341 W Pine St
Missoula, MT 59802
Phone: (406) 327-0269

Consent for Orgasm Shot® / O Shot® Procedure

(Vaginal Submucosal/Suburethral, Clitoral, and/or Labial Injection of Platelet Rich Plasma and Administration of Anesthesia)

A. CONSENT FOR ORGASM SHOT®/O SHOT® PROCEDURE

I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I have not received any promise, guarantee or warranty that my undergoing the Orgasm Shot®/O Shot® procedure will achieve a particular result. I fully understand that individual results do vary, and that Missoula Osteopathic Clinic, PLLC and Dr. Postlethwaite assume no responsibility for failure to achieve a desired result.

I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

1. I authorize Dr. Postlethwaite to treat my condition, including performing further diagnosis and the procedures described below, and taking any needed photographs.

2. I understand the proposed Orgasm Shot®/O Shot® procedure(s) to be: a procedure for vaginal, labial, and clitoral rejuvenation, using blood-derived growth factors (platelet-rich fibrin matrix (PRFM), platelet-rich plasma (PRP) injections.

3. I understand the risks associated with the proposed procedure(s) to be:

- Bleeding
- Infections
- Urinary retention
- No effect at all
- Allergic reactions
- Constant awareness of the G-Spot
- A sensation of always being sexually aroused
- Constant vaginal wetness
- Mental preoccupation of the G-Spot
- Alteration of the function of the G-Spot
- Sexual function alteration
- Hematoma
- Urethral injury (tube you urinate through)
- Urinary retention

- Hematuria (blood in urine)
- UTI (Urinary Tract Infection)
- Urinary Urgency
- Urinary Frequency
- Increased or worsening nocturia (waking up several times at night to urinate)
- Change in urinary stream
- Urethral vaginal fistula (hole between urethra and vagina)
- Vesico-vaginal fistula (hole between bladder and vagina)
- Dyspareunia (Painful intercourse)
- Need for subsequent surgery
- Alteration of vaginal sensations
- Scar formation (vaginal)
- Urethral stricture (abnormal narrowing of the urethra)
- Local tissue infarction and necrosis
- Yeast infections
- Vaginal Discharges
- Spotting between periods
- Bladder Pains
- Overactive Bladder (OAB)
- Bladder Fullness
- Exposed Material
- Pelvic Pains
- Pelvic Heaviness
- Erosions
- Fatigue
- Damage to nearby organs including bladder, urethra and ureters
- Alteration of bladder dynamics
- Post-operative pain
- Prolonged pain
- Intractable pain
- Alteration of the female sexual response cycle
- Failed procedure
- Varied results
- Psychological alterations
- Relationship problems
- Sex life alteration
- Decreased sexual function
- Possible hospitalization for treatment of complications
- Lidocaine toxicity
- Anesthesia reaction
- Embolism
- Depression
- Reactions to medications including anaphylaxis
- Nerve damage
- Permanent numbness
- Slow healing
- Swelling
- Sexual dysfunction
- Allergy
- Nodule formation

4. I also understand that there may be other RISKS OR COMPLICATIONS, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

5. I understand that the use of PRP in this procedure is an “off-label” use, and no promise or representation, guarantee or warranty regarding its use, benefit or other quality is made. No representations that the use of this product and this procedure is approved by the FDA or any other agency of the federal or state government is made. I understand the alternatives to the proposed procedures and the related risks to be: do nothing.

B. CONSENT FOR ADMINISTRATION OF ANESTHESIA
When local anesthesia and/or sedation is used by the physician:
I consent to the administration of such local anesthetics as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine.

C. PATIENT CERTIFICATION:
By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

Signature:_____ Date:_____

SIGNATURE OF PATIENT AND DATE

D. PHYSICIAN ATTESTATION
I have explained the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. The patient has verbally communicated to me that they understand the contents of this form.

Signature:_____ Date:_____

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT AND DATE

E. INTERPRETER ATTESTATION (when applicable)
I have provided translation to the person(s) whose signature(s) is affixed above.

Signature:_____ Date:_____

SIGNATURE OF INTERPRETER AND DATE (optional)

F. WITNESS ATTESTATION
I have witnessed the above physician or designee explain the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. I have witnessed the above patient verbally communicate to the above physician or designee that they understand the information and contents of this form.

Signature:_____ Date:_____

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NOTICE OF PRIVACY IN MEDICAL RESEARCH

We request your permission to study our therapeutic treatments. Medical research is essential for the advancement of healthcare as a whole and especially the development of alternative interventions, like the therapies provided in this treatment. At Missoula Osteopathic Clinic, your privacy is very important to us, and we will make every effort to protect it. This signature will represent the allowance of using non-identifiable data from your therapeutic treatment, including, but not limited to: general condition before/during/after treatment, treatment area, treatment methods, response to treatment, and results. Your name and contact information will not be disclosed. Your health information will be kept by your provider in Missoula Osteopathic Clinic's secure database. If information from this treatment is published or presented at scientific meetings, your name and other personal information will not be used.

_____
Patient Signature

_____
Date

Pre-Care Instructions:

● *Hydration* - We cannot stress this enough. 2-3 days PRIOR to your treatment attempt to drink 80 oz of water a day. Hydration will help your provider identify & access damaged tissues better under ultrasound, make the blood draw faster & easier, and optimize platelet concentration.
● *Comfortable Clothes* - Make sure to dress in clothing that allows the treatment area to be easily exposed.
● *Shaving* - Please shave the treatment area before your appointment
● *Medications* - **DO NOT** take Aspirin, Ibuprofen, Aleve, NSAIDS, allergy medicines (such as FloNase or Nasacort) and/or any oral/topical or inhaled steroids seven (7) days prior to treatment. Treatment may be delayed if taken within 7 days. Work with a physician to find effective substitutes for these medications as they contribute to the body degenerating.
Herbs: Many herbs that fight inflammation need to be avoided within 7 days of injections: turmeric, curcumin, willow, slippery elm, meadowsweet, are a few to note, but there are others. Please discuss all herbs you are taking with your physician.
● *Other* - **DO NOT** get vaccinated or donate blood/plasma within 6 weeks.

Female Sexual Function Index (FSFI)

Printed Name: _____ Date: _____

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

- Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.
- Sexual intercourse is defined as penile penetration (entry) of the vagina.
- Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.
- Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.
- Sexual arousal is a feeling that includes both physical and mental aspects of sexual
- excitement. It may include feelings of warmth or tingling in the genitals, lubrication
- (wetness), or muscle contractions.

CHECK ONLY ONE BOX PER QUESTION.

1. Over the past 4 weeks, how often did you feel sexual desire or interest?
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

3. Over the past 4 weeks, how often did you feel sexually aroused ("turned on") during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your level of sexual arousal during sexual activity or intercourse?
   - ☐ No sexual activity

- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

5. Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very high confidence
- ☐ High confidence
- ☐ Moderate confidence
- ☐ Low confidence
- ☐ Very low or no confidence

6. Over the past 4 weeks, how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

7. Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

8. Over the past 4 weeks, how difficult was it to become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

9. Over the past 4 weeks, how often did you maintain your lubrication until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)

- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

10. Over the past 4 weeks, how difficult was it to maintain your lubrication until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how was it difficult for you to reach orgasm?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

13. Over the past 4 weeks, how satisfied were you with your ability to reach orgasm during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

14. Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied

- ☐ Very dissatisfied

15. Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

16. Over the past 4 weeks, how satisfied have you been with your overall sexual life?
    - ☐ Very satisfied
    - ☐ Moderately satisfied
    - ☐ About equally satisfied and dissatisfied
    - ☐ Moderately dissatisfied
    - ☐ Very dissatisfied

17. Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?

    - ☐ Did not attempt intercourse
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

18. Over the past 4 weeks, how often did you experience discomfort or pain following vaginal penetration?
    - ☐ Did not attempt intercourse
    - ☐ Almost always or always
    - ☐ Most times (more than half the time)
    - ☐ Sometimes (about half the time)
    - ☐ A few times (less than half the time)
    - ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?
    - ☐ Did not attempt intercourse
    - ☐ Very high
    - ☐ High
    - ☐ Moderate
    - ☐ Low
    - ☐ Very low or none at all

Thank you for completing this questionnaire. We request that you follow up in three months and take this exam again. If you have any other feedback about your treatment, please feel free to email us at any time. missoulaosteopathic@gmail.com