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

Consent for Vaginal PRF/PRP Treatment and Intimate Wellness Procedure

A. PROCEDURE CONSENT

I understand that I am undergoing a procedure involving the injection of platelet-rich fibrin (PRF) and/or platelet-rich plasma (PRP) into vaginal, clitoral, labial, and/or periurethral tissues for the purpose of supporting sexual health, function, and/or urinary symptoms.

I acknowledge that:

- The nature of the procedure, its purpose, and expected benefits have been explained to me.
- I have had the opportunity to ask questions and have received satisfactory answers.
- I understand that results vary and **no guarantees** have been made regarding outcomes.
- I understand that this treatment may be used to address concerns such as sexual dysfunction, decreased sensation, vaginal dryness, or urinary incontinence, but results are not guaranteed.

I voluntarily consent to this procedure and authorize the provider to perform it, including any reasonable modifications necessary for my care.

B. RISKS AND COMPLICATIONS

I understand that all medical procedures carry risks. Potential risks of this procedure may include, but are not limited to:

- Pain, swelling, bruising, or bleeding
- Infection
- Urinary symptoms (including urgency, frequency, discomfort, or retention)
- Temporary or permanent changes in sensation
- Pain with intercourse
- No improvement in symptoms
- Allergic reaction or sensitivity to medications or anesthetics
- Nerve irritation or injury
- Scar tissue formation or nodules
- Injury to surrounding structures (including urethra or bladder)
- Need for additional treatment or procedures

I understand that **rare or unforeseen complications** may occur and that not all risks can be fully predicted.

C. OFF-LABEL USE

I understand that PRF/PRP use for this type of procedure is considered **off-label**, meaning it is not specifically approved by the FDA for this indication. I acknowledge that no guarantees have been made regarding its effectiveness.

D. ALTERNATIVES

I understand that alternatives include:

- No treatment
- Other medical or procedural options, which have been discussed with me

E. ANESTHESIA CONSENT

I consent to the use of local anesthetic as needed. I understand risks may include:

- Temporary discomfort, swelling, or bruising
- Allergic reaction
- Rare complications such as toxicity or seizure

F. PATIENT ACKNOWLEDGMENT

By signing below, I confirm that:

- I am 18 years of age or older, or legally authorized to consent
- I have read and understand this form
- My questions have been answered
- I voluntarily consent to this procedure

Patient Signature: _____ Date: _____

G. PROVIDER ATTESTATION

I confirm that I have explained the procedure, risks, benefits, and alternatives to the patient, and believe they understand and have provided informed consent.

Provider Signature: _____ Date: _____

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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.
    ❖ *We request that you follow up in three months. If you have any other feedback about your treatment, please feel free to email us at any time. missoulaosteopathic@gmail.com*

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

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