BTL EMSELLA™

GENERAL PATIENT RECORD

Patient's name:	**Date of birth:** **Age:**
Phone:	**Email:**

Diagnosis:

_____

TREATMENT CONSIDERATIONS

You are scheduled for a series of non-invasive treatments with the BTL EMSELLA device.

BTL EMSELLA is intended to provide entirely non-invasive electromagnetic stimulation of pelvic floor musculature for the purpose of rehabilitation of weak pelvic muscles and restoration of neuromuscular control for the treatment of urinary incontinence in women.

Initials: _____

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 6. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days, depending on your needs. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on the severity of your condition. The results will typically continue to improve over the next few weeks.

Initials: _____

There is typically no pain associated with your treatment and there is no anesthetic required. You will experience gradually increasing tingling feeling and muscle contractions. These sensations in the pelvic area are normal and expected. You remain fully clothed during the treatment.

Initials: _____

On the day of the treatment, you are advised to wear comfortable clothes which allow flexibility for correct positioning and increased comfort during the treatment.

Initials: _____

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Please answer whether you currently have or have had any of the following:

- pregnancy YES NO
- cardiac pacemakers YES NO
- implanted defibrillators, implanted neurostimulators YES NO
- electronic implants YES NO
- pulmonary insufficiency YES NO
- metal implants YES NO
- drug pumps YES NO
- hemorrhagic conditions YES NO
- anticoagulation therapy YES NO
- heart disorders YES NO
- malignant tumor YES NO
- fever YES NO
- allergy to any medications, food or other substances YES NO
- taking prescription, herbal, or over the counter medication YES NO
- any surgeries YES NO
- any skin disease or sensitivity YES NO

If you answered YES to any of these questions, please specify:

For the full range of contraindications, warnings and cautions, consult your treatment provider.

- I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment. **Initials: _____**
- I am aware that I can't undergo the treatment when menstruating. **Initials: _____**

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- I understand there are certain risks associated with BTL EMSELLA treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials: _____**
- I am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:_____**
- I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. **Initials:_____**
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction.
  I fully understand the treatment conditions, the procedure and possible side effects. **Initials:_____**
- I have read the above information, and I request and give my consent to be treated with the BTL EMSELLA procedure by the physician(s) in the below stated practice and his/her designated staff. **Initials:_____**

My signature below indicates that the above information is accurate and current.

Patient signature:_____
Date:_____

Witness (in print):_____ **Signature:** _____
Date:_____

Practice Name: _____

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