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 **Tina Johnson, R.N.,** assumes 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 rest interests and where delay might impair my health.

1. I authorize **Tina Johnson, R.N.,** 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)
Hematuria (blood in urine)
UTI (urinary tract infection)
Urinary Urgency (feels like you always have to pee)
Urinary Frequency
Increased/worsening nocturia (waking up several times at night to urinate)
Change in urinary stream
Urethra 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)
Urethra 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 heaviness
Erosions Fatigue

List Continued on next page **PATIENT INITIALS** _____

Damage to nearby organs including bladder, urethra, and ureters	Possible hospitalization for treatment of complications
Post-operative pain	Lidocaine toxicity
Prolonged pain	Anesthesia reaction
Intractable pain	Embolism
Alteration of the female sexual response cycle	Depression
Failed procedure	Reactions to medications including anaphylaxis
Varied results	Nerve damage
Psychological alterations	Slow healing
Relationship problems	Swelling
Sex life alteration	Sexual disfunction
Decreased sexual function	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 procedures.
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 the state government is made. I understand the alternatives to the proposed procedures and the related risks has been explained to me.

CONSENT FOR ANESTHESIA

When local anesthesia is used by the nurse:

I consent to the administration of such local anesthetics that may be considered necessary by the nurse 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.

B. 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 have had explained to me the consents 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.

X_____

Name (print) **Date**

X_____

Signed Name **Witnessed Signed**

LASTING Impressions

Pre and Post Treatment Instructions for O-Shot PRP Instructions

Before: The week before having the treatment (for best results):

1. AVOID the use of NSAIDS (ibuprofen, Motrin, Aleve, Naproxen, Aspirin, etc.) **5 days before procedure** (Tylenol is OK for pain relief right up to and including the day of procedure, do not exceed 4000MG in a 24-hour period).
2. AVOID the following nutritional supplements for **5 days before procedure**: gingko biloba, garlic, vitamin E, vitamin A, Flax Oil, Curcumin and other anti-inflammatory nutrients.
3. AVOID the systemic use of corticosteroids for **1 week before the procedure**.
4. AVOID alcohol and cigarettes for **5 days before the procedure.**
5. HYDRATE very well the day **before and the day after** the procedure for ease of blood draw.
6. SHAVE the treatment area within **24 hours** of the procedure.

DURING: The day of the procedure:

1. All paperwork will be completed (personal medical history and informed consent)
2. Blood is drawn and PRP is processed.
3. Topical numbing cream is applied to injection site(s). Additional lidocaine may be injected after topical numbing attained.
4. PRP is processed, activated, and injected into 3 to 4 areas.
5. APEX/Intensity pelvic exerciser with its instructions will be provided.
6. Schedule a 4 week follow up appointment.

AFTER: The week(s) after the procedure (for best results):

1. Mild bruising and irritation may occur.
2. Follow the post procedure APEX/Intensity protocol (10 minutes daily).
3. AVOID the use of NSAIDS (ibuprofen, Motrin, Aleve, Naproxen, Aspirin, etc.) for **5 days after the procedure** (Tylenol is OK for pain relief, do not exceed 4000MG in a 24-hour period).
4. AVOID the following nutritional supplements for **5 days after the procedure**: gingko biloba, garlic, vitamin E, vitamin A, flax oil, curcumin and other anti-inflammatory nutrients.
5. AVOID the systemic use of corticosteroids for **2 weeks after the procedure.**
6. AVOID alcohol and cigarettes for **5 days after the procedure.**
7. EAT a healthy diet and HYDRATE very well: at least 64 ounces of clean fresh water.
8. Make 4-week follow-up appointment with **Tina Johnson, R.N. at (903)-814-7760** for further instructions and intervention if necessary.

PATIENT INITIALS:_____

LASTING Impressions

PATIENT COPY-KEEP FOR YOUR RECORDS

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