Consent for Vaginal Submucosal/Suburethral, Clitoral, and/or Labial Injection of Platelet Rich Plasma [OShot(R)]

A. CONSENT FOR PROCEDURE [O-Shot(R)]
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 understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the use of topical (lidocaine) and local anesthetic.

1. I authorize Calista Skin & Laser employees to treat my condition, including performing further diagnosis and the procedures described below, and taking any needed photographs.

2. I understand the proposed procedure(s) to be: vaginal submucosal/subureathral, clitoral, and labial, PRP injection [The O Shot(R)].

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

Variable Response	Infections	Urinary retention
Post-operative pain	Hematuria (blood in urine)	Constant awareness of the G-Spot
Constant vaginal wetness	Decreased sexual function	Sexual dysfunction
Alteration of the function of the G-Spot	Nodule formation	Vaginal Discharges
Urethral injury	Urinary retention	UTI (Urinary Tract Infection)
Urinary Urgency	Urinary Frequency	Spotting between periods
Dyspareunia (Painful intercourse)	Overactive Bladder (OAB)	Bladder Fullness
Lidocaine reaction and/or toxicity	A sensation of always being sexually aroused	
Increased/worsening nocturia (waking up at night to urinate)		

4. I also understand that there may be other risks or complications associated with the procedure 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.

I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine. I have no allergy to lidocaine _____ initial

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 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 of Patient Date

C. 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 of Physician or designee obtaining consent Date