THIS FORM IS FOR VAGINAL SUBMUCOSAL/SUBURETHRAL, CLITORAL, AND/OR LABIAL INJECTION OF PLATELET RICH PLASMA (O-SHOT®) AND ADMINISTRATION OF ANESTHESIA.

Introduction: This is an informed consent that has been prepared by to help inform you concerning the O-shot®, its benefits and risks. This document may help you decide whether to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

The O-shot® is a non-surgical treatment that uses your own blood platelets to activate growth factors that will help rejuvenate the female orgasm system. This procedure starts with a blood draw, then using a centrifuge, will separate out the PRP (platelet rich plasma) containing the growth factors. After a topical numbing agent has time to numb the area, the PRP is then injected into an area near the clitoris and into the area of the upper vagina that is important for sexual response. This procedure has very little to no discomfort.

The O-shot® should not be administered to a pregnant or nursing woman. If there is a chance of pregnancy, inform the staff immediately.

Benefits:

- Greater arousal from clitoral stimulation
- Increased sexual desire
- Younger, smoother skin of the vulva (lips of vagina)
- Increased ability to have a vaginal orgasm
- A tighter introitus (vaginal opening)
- Decreased pain for those with dyspareunia (painful Intercourse)
- Stronger orgasm
- Increased natural lubrication
- More frequent orgasm
- Decreased or resolved urinary incontinence (both urge and stress problems)

This list is not meant to be inclusive of all possible risks associated with the O-shot® as there are both known and unknown side effects associated with any medication or procedure.

Risks:

- Bleeding
- Increased/worsening nocturia
- Infection
- Change in urinary stream
- Urinary retention
- Urethral vaginal fistula (hole between urethra & vagina)
- No effect at all
- Vesico-vaginal fistula (hole between bladder & vagina)
- Allergic reactions
- Dyspareunia (painful intercourse)
- Constant awareness of the G-Spot
- Nerve damage
- Constant vaginal wetness
- Sexual function alteration
- Mental preoccupation of the G-Spot
- Alteration of vaginal sensations
- Alteration of the function of the G-Spot
- Scar formation (vaginal)
- Hematoma
- Bladder Fullness
- Vaginal discharge
- UTI (Urinary Tract Infection)
- Urethral injury (tube you urinate through)
- Urinary Urgency (feel like you always have to urinate)
- Hematuria (blood in urine)
- Lidocaine toxicity
- Local tissue infarction and necrosis
- Anesthesia reaction
- Alteration of the female sexual response cycle
- Reactions to medications including anaphylaxis
- Failed procedure
- Sex life alteration
- Varied results
- Swelling
- Damage to nearby organs including bladder, urethra and ureters

I have received a consultation regarding my condition, the proposed treatment, alternatives, and related risks. 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 procedure(s). 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.

I authorize my practitioner to treat my condition, including performing further procedures, and document with photographs, if needed.

Additionally, I consent to the administration of such local anesthesia as may be considered necessary by the physician/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.

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. No refunds will be given for treatments rendered.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear cost of the collection, and/or court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. All my questions have been answered to my satisfaction and I hereby give consent to perform this and all subsequent O-Shot® treatments with the above understood. I understand I have the right to refuse treatment. I hereby release the doctor, the person administering the O-Shot®, and the facility from liability associated with this procedure.

Patient Signature: _____

Date: _____