RESTORE MEDICAL
TARPORLEY

ULTRA TESLA SEAT TREATMENT CONSENT FORM

Patient name:	Date of birth:
Email:	Telephone number:

Do you have any of the following? (if YES please tick)

Absolute Contraindications (Treatment NOT Recommended)

- ☐ Pregnant /Breastfeedng
- ☐ Plastic IUD (Intrauterine Device) fitted in last 12 weeks
- ☐ Metal implants in the treatment area (hip replacements, metal mesh, copper IUD, screws, plates)
- ☐ Pacemaker, defibrillator, or other electronic medical implants (insulin pump, cochlear implant, neurostimulator)
- ☐ History of or active pelvic cancer
- ☐ Uncontrolled bleeding disorder or taking blood thinners
- ☐ Severe urinary or fecal incontinence requiring medical intervention
- ☐ Active urinary tract infection (UTI) or pelvic infection
- ☐ Recent pelvic surgery (not fully healed)
- ☐ Open wounds, burns, or lesions in the pelvic area
- ☐ Severe neurological disorders affecting the pelvic floor (e.g., multiple sclerosis, spinal cord injury)

Relative Contraindications (Consult Your Doctor/Therapist Before Treatment)

- ☐ History of endometriosis or chronic pelvic pain
- ☐ Osteoporosis or fragile bones in the pelvic area
- ☐ Abdominal or pelvic hernia
- ☐ History of deep vein thrombosis (DVT) or blood clots
- ☐ Uncontrolled diabetes
- ☐ Recently gave birth (less than 6-8 weeks postpartum)
- ☐ Autoimmune disorders affecting muscle function (e.g., lupus, rheumatoid arthritis, myasthenia gravis)
- ☐ Chronic constipation or bowel disorders
- ☐ History of pelvic radiation therapy
- ☐ Fibroids or polyps that press on the bladder or pelvic muscles.
- ☐ Recent surgical procedures (past 12 months)
- ☐ Epilepsy or seizure disorder
- ☐ Currently menstruating (may cause discomfort)

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

- If you have any questions about the above please discuss these with your practitioner.
- If you have answered YES to any of the above your practitioner may ask for further details.
- Treatment may be refused if it is not considered to be in your own interest to proceed.

Please disclose any medical conditions that may be affected by Ultra Tesla Seat treatment. Failure to provide accurate medical information may increase the risk of adverse effects.

Treatment considerations	Initial
You are scheduled for a series of non-invasive treatments with the ULTRA TESLA SEAT device. ULTRA TESLA SEAT 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 and men.	
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 maximise 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.	
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.	
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.	
I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment.	
I understand there are certain risks associated with ULTRA TESLA SEAT treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, starting a period earlier, 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.	
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.	
I understand there are some rare side effects to the ULTRA TESLA SEAT such as, bleeding/spotting in post-menopausal women, mild diarrhoea and in a very small group of people their symptoms of incontinence may worsen before improving.	
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 recognisable result after the procedure. I acknowledge the results may not meet my expectations.	
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.	
I have read the above information, and I request and give my consent to be treated with the ULTRA TESLA SEAT procedure by the physician(s) in the below stated practice and his/her designated staff.	

As with most medical procedures, there are risks and side effects. These have been explained to me in detail.
I have read the above information, and I give my consent to be treated with the Ultra Tesla Seat.

Patient signature: Date:

Therapist signature: Date:

TREATMENT RECORD							
Date							
Session No.							
Condition Being Treated							
Treatment Time							
Preset Setting/ Mode							
Intensity (%)							
Number of Cycles							
Pause Duration							
Minimum Frequency							
Minimum Frequency							
Rise Time							
Down Time							
There have been no changes to my health since my last treatment. Signature	Signature	Signature	Signature	Signature	Signature	Signature	Signature

Notes: