

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

**A. CONSENT FOR PROCEDURE [O-Shot®]**

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 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 best interests and where delay might impair my health.

1. I authorize Dr. \_\_\_\_\_ 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/suburethral, clitoral, and labial, PRP (platelet rich plasma) injection [The Orgasm Shot®/The O Shot®].

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)

Urinary retention

Hematuria (blood in urine)

UTI (Urinary Tract Infection)  
Urinary Urgency (feel like you always have to urinate)  
Urinary Frequency  
Increased/worsening nocturia (waking up several times at night to urinate)  
Change in urinary stream  
Urethral 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)  
Urethral 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 Pains  
Pelvic Heaviness  
Erosions  
Fatigue  
Damage to nearby organs including bladder, urethra and ureters  
Alteration of bladder dynamics  
Post-operative pain  
Prolonged pain  
Intractable pain  
Alteration of the female sexual response cycle  
Failed procedure  
Varied results  
Psychological alterations  
Relationship problems  
Sex life alteration  
Decreased sexual function  
Possible hospitalization for treatment of complications  
Lidocaine toxicity  
Anesthesia reaction  
Embolism

Depression  
Reactions to medications including anaphylaxis  
Nerve damage  
Permanent numbness  
Slow healing  
Swelling  
Sexual dysfunction  
Allergy  
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 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.

#### A. CONSENT FOR ANESTHESIA

When local anesthesia and/or sedation is used by the physician:  
I consent to the administration of such local anesthetics as may be considered necessary by the physician 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 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 and 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 and  
DATE

D. INTERPRETER ATTESTATION (when applicable)

I have provided translation to the person(s) whose signature(s) is affixed above.

\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE OF INTERPRETER and DATE