resolution
PHYSIOTHERAPY & IMS CLINIC

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Pessary Device Prescription

Patient Name _____ Date _____

Pessary Indication: ☐ POP (Pelvic Organ Prolapse) ☐ SUI (Stress Urinary Incontinence

The above-named patient is interested in being assessed and fitted for a Pessary Device for the above selected indication. As is required prior to her fitting, I have completed a gynecological assessment to determine the safety of a Pessary Device for this patient.

I confirm that I have assessed the above-named patient and have cleared the above-named client for all of the following contraindications to the use of a Pessary Device:

- undiagnosed bleeding
- severe vaginal atrophy
- active infection (vaginal, UTI, vulvar)
- ulceration or lacerations of the cervix or vagina
- cancer or the vagina, vulva, uterus or bladder
- active inflammatory disease of the pelvic floor
- endometriosis
- pregnant
- uncontrolled diabetes
- ano-perineal lesions with Crohn's disease
- silicone allergy
- gynecological surgery with mesh

As I have determined there are no contra-indications present and I agree that the above-named patient would benefit from the use of a pessary:

I prescribe a custom fit Pessary Device for the above-named patient and I give permission for a Pessary Trained Pelvic Physiotherapist at Resolution Physiotherapy to assess and fit this patient with a Pessary and train her in safe usage of this device.

Additional comments:

Physician Name _____ Physician Signature _____