

Dover Women's Health, P.A.
700 Central Ave.
Dover, NH 03820
603-742-2424

Your First Visit for Pelvic Floor Physical Therapy

Your first visit with our Nurse Practitioner will take approximately one hour. At your visit the Nurse Practitioner will take a health history and perform an examination to evaluate the cause for your bladder problem. If you have not recently had a urine test performed you should come expecting to give a specimen.

An abdominal and pelvic examination is then performed on female patients to ensure there is no secondary cause for the bladder problem.

Following the examination, muscle testing of the pelvic floor muscle will be performed. This procedure is not uncomfortable.

This is done one of two ways. (1) A small sensor is placed in the rectal opening and you will be asked to tighten the rectal muscle as if you were holding back gas. The reason for these instructions is all the pelvic floor muscles attach into the rectum. Therefore it is easier to contract the larger muscle of the rectum and it automatically tightens the rest of the muscles, which control bladder leaking or urinary frequency and urgency. (2) A small sensor like a tampon is placed in the vagina and the same instructions are given as above.

The muscle testing is important because no two people are exactly alike. The level of exercise we recommend will be based on the muscle testing. If too many exercises are performed it may actually fatigue the muscle. If not enough are performed the muscle will not improve.

Additional treatments, which may be incorporated, are:

1. Stimulation to the muscle. This is done with the vaginal sensor in women, which is inserted like a tampon. You will feel a gentle tapping sensation and feel the muscle contract. This is not uncomfortable for most people. This is

the same type of therapy used for people who have difficulty with urgency and frequency by helping control the bladder.

2. Dietary habits will be reviewed. We find some patients have bladders that are very sensitive to certain types of drinks or foods. Dietary changes may be recommended.

We find 75-80% of the patients we see will attain significant improvement or cure with this type of therapy alone. As with any form of treatment there are some patients who do not benefit from non-surgical therapy. We recommend appointments every one to two weeks initially depending on your symptoms or progress. The average number of visits is 6-8. There are some people that require less visits and of course those who sometimes require more. Change in our symptoms should be noticed in 3-4 visits if non-surgical therapy is going to be successful to you. This does not mean you will be cured in 3-4 visits but you should notice gradual progress. Remember loss of bladder control did not just happen overnight. We are working with the same muscles that have become weak so success does take some time and most importantly it requires specific exercises and recommendations be followed. Occasionally we will also recommend medications if we feel they are warranted.

We encourage our patients to continue any vacations or travels you may have planned. Instructions may be given to keep your status of rehabilitation until you can return. Follow-up visits usually take 30 minutes.

If you need to reschedule your appointment we ask when possible to do so 24 hours in advance. We look forward to seeing you at your visit.

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**PELVIC FLOOR MUSCLE THERAPY
AND REHABILITATION**

You have been recommended, and/or scheduled, for Pelvic Floor Muscle Therapy and Rehabilitation. If you have already been scheduled, your appointments for this service are listed below.

The cost for each session can exceed \$1000.00.

Although most insurance plans will cover this service, we **strongly recommend** that you contact your insurance carrier to obtain your **exact benefit level for this service**. This therapy typically consists of four codes, which are billed to your insurance carrier.

Please provide the codes below to your insurance carrier and ask for the benefit available for each code. This is **important** because many times insurance carriers **apply a different benefit to each code** (i.e., two of the codes are physical therapy, one is surgical, and the other is diagnostic). **Also, please ask if “prior authorization” is required for any of these services, and if so, please let us know before your appointment.**

<u>Code</u>	<u>Benefit Available</u>	<u>Prior Authorization Needed</u>
91122		Yes or No
51784		Yes or No
97750		Yes or No
97032		Yes or No

Name of Representative: _____ Reference # _____

****Please be sure to document the full name of the insurance representative you speak with and ask them to provide you with a “call reference number”****

This will enable you to obtain your expected out of pocket expense for this service.

Pelvic Floor Muscle Physical Therapy Appointments for you are as follows. Each appointment lasts approximately 1 hour:

_____	_____
_____	_____
_____	_____
_____	_____

****A minimum of 24 hours cancellation notice is required for your appointments****

If you have any questions after verifying your insurance benefits, please contact our billing department at (603) 742-2424 for assistance.

Intake Questionnaire

Name: _____
 DOB: _____
 Referring Physician: _____
 Date/Time completed: _____

- 1) When did your urinary loss start?
 - Less than 6 months
 - More than 6 months
 - More than 1 year
 - More than 2 years
 - More than 3 years
 - More than 5 years
- 2) Was it associated with a specific event?
 - Childbirth
 - Surgery
 - Menopause
 - Medical illness
 - Other: _____
- 3) How has the incontinence changed over time?
 - Stayed the same
 - Improved
 - Worsened
- 4) When do you lose urine?
 - Daytime
 - Nighttime
 - Both day and night
- 5) How many times per day do you lose urine?
 - Once
 - Twice
 - Three
 - More than three
 - Constantly
- 5) How much urine do you lose during an accident?
 - Teaspoonful
 - Tablespoonful
 - 1/2 Cup
 - More than 1 cupful
- 7) What type of protection do you use to stay dry?
 - None
 - Panty liner
 - Mini-pad
 - Maxi-pad
 - Diaper
 - Other: _____
- 3) How often do you change the protective device on an average day?
 - Zero
 - Once
 - Two to three times
 - Three to four times
 - Five to six times
 - More than six times
- 9) What causes you to lose urine? (Check all that apply)
 - Cough
 - Laugh

- Sneeze
- Putting key in the door
- Handwashing
- Physical activity
- Other: _____

10) Do you have an urge or warning before the bladder accident?
 Yes
 No

11) Do you lose urine when sitting still?
 Yes
 No

12) Do you lose urine on the way to the bathroom?
 Yes
 No

13) How many times do you urinate during the day?
 Once
 Two to three
 Three to four
 Four to five
 Five to six
 More than six

14) How many times do you wake up to urinate at night?
 Zero
 Once
 Two to three
 Three to four
 Four to five
 Five to six
 More than six

15) How many glasses of fluid do you drink per day?
 One glass
 Two glasses
 Three glasses
 Three to five glasses
 Five to seven glasses
 Seven to nine glasses
 More than nine glasses

16) Do you feel that you empty your bladder completely?
 Yes
 No

17) If you have had previous urologic surgery,
 please fill in the blanks with corresponding dates:

18) If you have had gynecological surgery,
 please fill in the blanks with corresponding dates:

19) Have you ever seen blood in your urine?
 Yes

No

20_a) Do you have a history of urinary tract infections?

Less than 6 months

More than 6 months

20_b) If yes, please state how often in the past year:

21) How many vaginal deliveries have you had?

Zero

One

Two

Three

Four

Five or more

22_a) Have you had any type of cancer?

Yes

No

22_b) If yes, please describe:

23) Have you been diagnosed with any of the following conditions?

Neurologic problems

Multiple sclerosis

Parkinson's disease

Stroke

Disc surgery

Back problems

Spinal injury

24_a) Do you have diabetes?

Yes

No

24_b) If yes, do you take insulin?

Yes

No

25_a) Do you have hypertension?

Yes

No

25_b) If yes, do you take a diuretic?

Yes

No

26) Do you have glaucoma?

Yes

No

27) Please check any of the following conditions that apply to you:

Heart disease

Lung disease

Stomach problems

Liver problems

Bowel difficulty

Other: _____

28_a) Do you have any allergies?

Yes

No

28_b) If yes, please specify:

29) Please list all the medications you take,

including over-the-counter medications:

30) Please list any medication you have taken in the past to treat your bladder condition:

31) Did the previously listed medications help your bladder?

- Yes
- No

32) Please list the names and addresses of the doctors that you would like to receive a report of your urologic evaluation:

33) Please identify the name and telephone number of the pharmacy that you currently use:

34) Please use this space to list anything else that you feel may be important about your bladder condition:

