Children's Urology Associates
an affiliate of MEDNAX

CONSENT FOR PELVIC EXAMINATION

PATIENT NAME: _____ DATE OF BIRTH: _____

As written in Florida Statue 456.51 a Pelvic Examination requires an informed consent.

According to the Statues a Pelvic Examination is defined as "the series of tasks that comprise an examination of the internal and external, male or female genitalia or rectum, using a combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation." For the purpose of this consent, instrumentation includes vaginal speculum and/or catheterization.

A pelvic examination may be performed by the Nurse Practitioner (ARNP) _____, Physician Assistant _____ and/or Medical Doctor _____ who will be seeing your child today.

Potential risks of a pelvic exam may include (but are not limited to) pain or discomfort. There are a few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set or risks. If you have concerns, you should discuss with your healthcare provider.

I hereby give Pediatrix Medical Group, Children's Urology Associates, the permission to perform a clinically indicated "Pelvic Examination".

1. The purpose, procedure, risks involved and possible alternative methods of treatment have been explained to me. I also understand that the information given to me does not list every possible risk and that other, less likely problems could occur.
2. I understand I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the Physician, Nurse, or sonographer if I am having any discomfort and/or unusual symptoms during the procedure.
4. I have read this consent form and understand its terms, and I am signing it knowingly and voluntarily.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

NAME: _____ DATE: _____

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COVID-19 SCREENING

The safety of our patients and staff is of utmost importance to Children's Urology Associates. Given the recent COVID-19 outbreak, the following pre-visit screening questions are designed to help promote your safety, as well as the safety of our staff and the other patients. Please answer these questions truthfully and accurately. All your responses will remain confidential.

Question	Yes/No	Details
Have you or a member of your household had any of the following symptoms in the last 14 days?: • Sore Throat • Cough • Chills • Body Aches for unknown reasons • Shortness of breath for unknown reasons • Loss of smell/loss of taste • Fever, temperature at or greater than 100 degrees Fahrenheit	Y / N	
Have you or a member of your household been tested for COVID-19?	Y / N	
Have you or a member of your household been advised to be tested for COVID-19? Or advised to self-quarantine for COVID-19?	Y / N	
Have you or a member of your household visited or received treatment in a hospital, or other health care facility in the past 14 days?	Y / N	