O-Shot

O-Shot

Status: active Form type: default Company: Acme Inc

TREATMENT OVERVIEW

The O-Shot (Orgasm Shot) is a non-surgical treatment that involves injecting Platelet-Rich Plasma (PRP), derived from your own blood, into specific areas of the vagina to stimulate tissue regeneration, improve sexual function, and enhance urinary control. This treatment is commonly used to address symptoms such as decreased libido, vaginal dryness, difficulty achieving orgasm, and mild urinary incontinence.

INTENDED BENEFITS

Enhanced sexual arousal and sensitivity Improved ability to achieve orgasm Increased vaginal lubrication Strengthened pelvic floor muscles Reduction in urinary incontinence symptoms Natural stimulation using your own PRP

POTENTIAL RISKS AND SIDE EFFECTS

Mild discomfort or bruising at the injection site Temporary swelling or redness Infection (rare) No guaranteed improvement in symptoms Allergic reaction (extremely rare due to use of autologous PRP)

CONTRAINDICATIONS

Active vaginal or pelvic infection Pregnancy or breastfeeding Blood disorders or use of blood-thinning medications Recent vaginal surgery Autoimmune conditions affecting healing Low platelet count or poor-quality PRP

PRE-TREATMENT INSTRUCTIONS

Avoid anti-inflammatory medications (e.g., ibuprofen) for 3–7 days prior Hydrate well for several days leading up to the procedure Ensure no active infection or lesion in the treatment area Inform your practitioner of any changes to your health or medications

POST-TREATMENT AFTERCARE

Avoid sexual intercourse for 24–48 hours post-procedure Mild spotting or swelling may occur – this is normal Resume normal activities as tolerated unless otherwise instructed Report any signs of infection or unusual discomfort to your practitioner immediately Follow up as recommended for assessment and maintenance

INFORMED CONSENT AND PHOTOGRAPHY

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

☐ I will retain this information throughout the course of my treatment and refer to it as required.