

Softwave Therapy Patient Consent Form

Name: _____ DOB: _____

Address: _____ Marriage Status: D_ M_ S_ W_

City, State, Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Relationship _____

Emergency Contact Phone: _____

Suitability for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Have you been injected with cortisone this month? Yes/No
- Are you using a cardiac pacemaker? Yes/No
- Do you have cancer / tumor? Yes/No
- Do you have a skin infection? Yes/No
- Are you pregnant or do you suspect you may be pregnant? Yes/No
- Are you under 16 years of age? Yes/No

Main Complaint: _____

2nd Area: _____

Pain Scale (1-10): _____

RISK OF THIS PROCEDURE

Pain and soreness. This is temporary and resolves after a few days.

The FDA has labeled this a “non-significant risk” therapy.

Consent for Procedure

I, _____, the Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition.

I have been fully informed of ESWT which the use of has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Signed: _____ Date: _____

SOFTWAVE

Tissue Regeneration Technologies

Post Treatment Info:

Now that you have experienced your first ever Softwave Tissue Regeneration treatment, here are a few things that you can do to ensure you have the best possible outcomes.

- Electrohydraulically produced 3,355 miles per hour.
- Breaks up scar tissue
- Decreases inflammation and pain at the treatment site.
- Stimulates your own stem cells
- 45 minute treatment

Typically after the 3rd treatment you should see a 60-75% reduction in pain. After 10-12 treatments we should have the max production

#1 – For the next 15-20 hours, you should notice the most decrease in pain and swelling, as well as an increase in range of motion and circulation.

#2 – The TRUE healing will be 8-12 weeks from now when the maximum amount of stem cells have been produced and migrated to the treated area.

#3 – Please do not ice or take any Advil or Ibuprofen. Take care and rest the next 2-3 days until your next session. Do not go do rigorous exercise tomorrow even though you may feel great! We just ignited a healing process and we want your body to work on that instead of working on additional stress to the treated area.

AFTER YOUR PROCEDURE

- Pain relief will not be immediate. You should expect to feel relief anywhere from 2-4 weeks to a few months after the procedure depending on where the procedure was done.
- Everyday activities are OK after the procedure, but exercise limits are listed below.
- You should expect to have some discomfort after the procedure. Not all patients experience pain, but those who do have pain can expect it to lesson after 3-4 days.
- Ice can be used as often as needed after the first 24-48 hours; however, it is not recommended that you use heat on the procedure area until after 3-4 days as it can increase pain.
- Tylenol (acetaminophen) and prescription pain medication may be used for any discomfort, but NSAIDs are **NOT** recommended for at least 4 weeks.

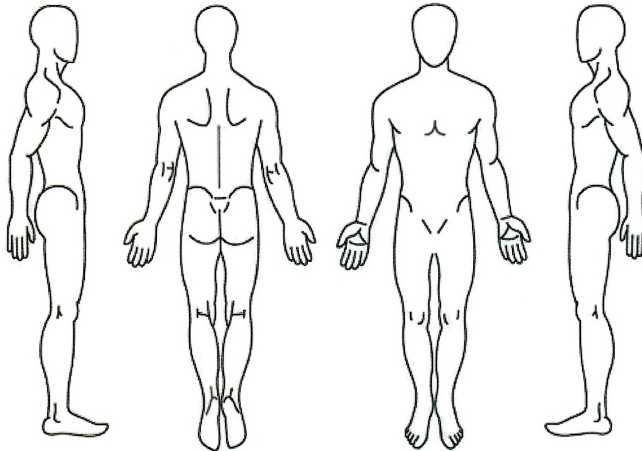
SoftWave

Tissue Regeneration Technologies

Progress Notes

Last Name: _____

Date: _____



T = Tenderness, **S** = Spasm, **TP** = Trigger Point, **P** = Pain, **L** = Left, **R** = Right

A = Absent, **D** = Decreased, **I** = Increased, **L** = Left, **R** = Right, **B** = Bilateral

Complaints & Functional Assessment Pre-Treatment

How do you feel today on a scale of 1-10 (10 being the worst)

_____ (___/10)

_____ (___/10)

_____ (___/10)

Motions/actions that cause pain:

1. _____
2. _____
3. _____

Days After Regenerative Procedure	Medications	Limits	Activity Recommendations
0-3	<ul style="list-style-type: none"> • Avoid all NSAIDs • Tylenol and pain medication as prescribed by your physicians is OK • Medications listed on the discontinue page should not be taken 	<ul style="list-style-type: none"> • No heat on injection site, use ice as much as needed for pain • Using a brace is recommended 	<ul style="list-style-type: none"> • Rest as much as possible • Day to day activities OK • No excessive exercise or weight training • No deep tissue massage
4 days-2 weeks	<ul style="list-style-type: none"> • Avoid all NSAIDs • Tylenol and pain medication as prescribed by your physicians is OK • Medications listed on the discontinue page should not be taken 	<ul style="list-style-type: none"> • Do not use ice on injection site • Heat is allowed 	<ul style="list-style-type: none"> • Day to day activities OK • Range of motion stretching OK • No excessive exercise • No deep tissue massage
2-4 weeks	<ul style="list-style-type: none"> • Avoid all NSAIDs • Tylenol and pain medication as prescribed by your physicians is OK • Medications listed on the discontinued page should not be taken 	<ul style="list-style-type: none"> • No restrictions 	<ul style="list-style-type: none"> • Weight training with low weight acceptable • Trigger point massage OK • Light aerobic exercise
4 weeks	<ul style="list-style-type: none"> • Medications can be taken as needed, no restrictions 	<ul style="list-style-type: none"> • Follow up with doctor to see if another injection is necessary 	<ul style="list-style-type: none"> • May resume normal exercise