**Consent Form for the Use of Therapeutic Ultrasound in Foot Health Treatments**

**Practice Name:**

**Clinician’s Name:**

**Date of Treatment**

Patient Name:

Date of Birth:

Address:

Contact Number:

**Explanation of Therapeutic Ultrasound**

Therapeutic ultrasound is a non-invasive treatment that uses high-frequency sound waves to help reduce pain, improve circulation, and promote tissue healing. It is commonly used to manage conditions such as plantar fasciitis, tendonitis, and soft tissue injuries.

While therapeutic ultrasound is generally safe, it is important to understand the potential benefits and risks before proceeding with treatment.

**Potential Benefits**

Pain relief and reduced inflammation.

Improved blood flow and tissue repair.

Non-invasive and painless treatment option.

**Possible Risks**

Mild discomfort or warmth during treatment.

Temporary redness or sensitivity in the treatment area.

Rare cases of irritation if used improperly.

**Patient Declaration**

I confirm that:

1. The nature and purpose of therapeutic ultrasound have been explained to me, including its potential benefits and risks.
2. I have had the opportunity to ask questions, and these have been answered to my satisfaction.
3. I understand that therapeutic ultrasound may not guarantee a specific outcome, as individual responses to treatment may vary.
4. I understand that I can withdraw my consent at any time without affecting my future care.
5. I have informed the practitioner of any medical conditions, allergies, or implants (e.g., pacemakers, metal implants) that may affect my suitability for this treatment.

**Contraindications (Tick if applicable):**

☐ Pregnancy

☐ Active infection or open wound in the treatment area

☐ Cancerous lesions in the treatment area

☐ Deep vein thrombosis or blood clots

☐ Sensory impairment or reduced sensation in the treatment area.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**

**For Practitioner Use Only**

Treatment Area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency : 1mHz

Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes/Observations:

This consent form will be kept securely in accordance with GDPR and the clinic’s data protection policy. If you have any questions after treatment, please contact the clinic directly.