CONSENT FORM FOR VASTI TREATMENTS

Clinic Name: _____ **Date:** _____
Doctor Name: _____
Patient Name: _____

Selected Vasti Treatment

- ☐ Kati Vasti (Lumbar Region)
- ☐ Janu Basti (Knee Joint)
- ☐ Greeva Basti (Cervical Region)
- ☐ Spinal Basti (spine)
- ☐ Hridya Basti (Heart region)
- ☐ Shiro Basti (Head)
- ☐ Netra Vasti (eyes)

Consent to Undergo Vasti Therapy

I, the undersigned, hereby consent to undergo Vasti therapy, which includes one or more of the following procedures: Kati Vasti (lumbar region), Janu Basti (knee joint), or Greeva Basti (cervical region),Spinal Basti (spine), Hridya Basti (Heart region),Shiro Basti (Head), Netra Vasti (eyes) at the above-mentioned clinic. I understand that this therapy involves the application of warm medicated oil retained in a reservoir made of dough placed over the affected area.

Acknowledgment of Information

1. **Therapy Purpose:**
   - I understand that Vasti therapy is designed to relieve pain, reduce inflammation, and improve circulation in specific areas of the body, depending on the targeted region.
2. **Procedure and Potential Benefits:**
   - I have been informed about the procedure, its potential benefits (e.g., pain relief, muscle relaxation, and improved mobility), and its role in promoting healing and well-being.
3. **Possible Risks and Side Effects:**
   - I am aware of possible side effects, such as temporary skin irritation, mild discomfort, redness in eyes or sensitivity to the medicated oil, and understand that these are generally rare and transient.
4. **Precautions Taken:**
   - I have disclosed all relevant medical information, including any allergies, skin conditions, or other health concerns, to the attending doctor.
5. **Voluntary Participation:**
   - I confirm that I am undergoing Vasti therapy voluntarily and understand that I may discontinue the session at any time.

Declaration

By signing below, I acknowledge that I have read and understood the information provided about Vasti therapy. I have had the opportunity to ask questions, and my concerns have been addressed to my satisfaction. I consent to receive the therapy under the care of the attending doctor at the above-mentioned clinic.

Patient Signature: _____ **Doctor Signature:** _____
Date: _____ **Date:** _____

Witness (if applicable): _____
Date: _____