Consent For Vein Procedure

AHVC
ADVANCED HEART & VEIN CENTER

I, _____ authorize the Provider or his/her designee and such other physicians, medical residents, physicians-in-training or other persons as are needed to assist him to perform the following procedure in the office:

Radiofrequency Ablation of: ☐ Great Saphenous Vein ☐ Lesser Saphenous Vein | ☐ L ☐ R

Venaseal: ☐ GSV ☐ SSV | ☐ L ☐ R ☐ **Laser of:** _____ | ☐ L ☐ R

Sclerotherapy: ☐ Right Leg: _____ ☐ Left Leg: _____

Varithena: ☐ Right Leg:_____ ☐ Left Leg: _____

The reason for this procedure is due to the following diagnoses: Venous Insufficiency with:

_____

Alternatives to performing this procedure include: Conventional therapies such as leg elevation and compression stockings. Please note that conventional therapies are used to treat the symptoms of your condition, not the condition itself.

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These are not all the possible risks associated with this procedure, but these risks can be serious and possibly fatal. Some significant and substantial risks of this operation or procedure include incomplete closures, skin burns and ulceration, scarring, and hyper-pigmentation.

Additional Procedures: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize him/her to perform such treatment, as he/she deems necessary.

Photography: I consent to the photographing of procedures performed, including appropriate portions of my body for medical, scientific, or educational purposes, providing that my identity is not revealed by the picture or descriptive texts accompanying them.

Tissue Disposal: I consent to the examination and disposal of any tissues or body parts that may be removed.

No Guarantee: I understand that no guarantee or assurance has been made to the results of the procedure and it may not cure the condition. Specifically no guarantee written or expressed is given stating that varicose veins or “spider veins” will completely resolve with this therapy.

Patient’s Consent: I have read and fully understand this consent form. I understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the items or words contained on this consent form. I understand that I can withdraw this consent to the procedure at any time before the beginning of the procedure. Do not sign unless you have read and thoroughly understand this form.

Patient Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

Provider Declaration: I have explained to the patient/patient’s representative the procedure and the risks, benefits, recuperation and alternative (including the probable or likely consequences if no treatment is pursued). I have answered all of the patient’s questions and to the best of my knowledge, I believe the patient has been adequately informed.

Pt DOB: _____