

## **Informed Consent and Authorization to perform Procedure Of Sclerotherapy**

**This form is designed to complement the explanation given by the doctor and provide you with the information you need to make an informed decision about whether to have sclerotherapy performed. Please read carefully the following information.**

**What is Sclerotherapy:** This is a popular method used to eliminate varicose veins in which a solution is injected into the veins, resulting in the obliteration of the vein. **Does sclerotherapy work on everyone:** The Majority of the persons who undergo this procedure will be cleared of their varicosities or at least see good improvement? Unfortunately, however, there is no guarantee that sclerotherapy will be effective in every case. Approximately 10% of patients who undergo this procedure have poor to fair results. Poor results mean that the veins have not totally disappeared after six treatments.

**Please Read Below the following risks and side effects of Sclerotherapy.**

- 1. The limitations and side effects of this procedure have been fully explained to me, and I fully understand them.**
- 2. You may experience mild itching along the vein route. Transient hype pigmentation; approximately 30% of the patients who undergo this procedure notice a discoloration of light brown streaks after treatment. The vein may become darker immediately after the procedure. In rare instances this darkening of the vein may persist 4 to 12 months. There is the possibility of permanent scarring and/or permanent pigmentation or a discoloration along the path of the vein.**
- 3. A blister may form, open and become ulcerated. The scar that follows should return to normal color. However, there is the possibility that the scar or ulcer may become permanent.**
- 4. Pain; a few patients my experience moderate pain and some bruising usually at the site of the injection. The veins may be tender to touch after treatment and uncomfortable Sensation may run along the vein route. The pain is usually temporary.**
- 5. Other side effects include a burning sensation during injection of the solution, neovascularization (the development of new tiny blood vessels), and transient phlebitis type reactions.**
- 6. I have been given post treatment instructions and understand the importance of following them.**
- 7. I will tell the Doctor of any recent treatments or changes to my skin. I understand that if I develop any adverse reaction to sclerotherapy I will call the doctor immediately or call 911 if applicable.**

8. I understand that Sclerotherapy requires further treatments to enhance the results.
9. I have to the best of my knowledge informed the Doctor of My Medical History.
10. Once I begin my treatment s of Sclerotherapy, The procedure is **not refundable**.

**I hereby authorize Dr: \_\_\_\_\_ and/or such assistants as may be selected by him/her to perform the Sclerotherapy Treatment, Again, I understand all the risks involved and the possibility that complications may arise. I acknowledge that no guarantee or assurance has been made regarding the results to be obtained by performing this procedure. The authority granted shall apply to each and every time I come to receive Sclerotherapy treatment, unless I cancel this authorization by written request. I consent to the Photos obtained for educational, scientific or advertising purposes. I understand that my identity will not be revealed. (HIPPA) My rights of privacy concerning my medical information have all been explained to me.**

**Patient Name (Print): \_\_\_\_\_**

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

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

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