

CONSENT FOR SUPERFICIAL VEIN CATHETER ABLATION

I hereby authorize Dr. _____ and associates/assistants and other healthcare providers he/she deems necessary, to perform the following procedure: _____

Dr. _____ has explained to me that I suffer from chronic venous insufficiency (CVI). Chronic venous insufficiency of the superficial veins is largely the result of abnormal vein valve function which results in the leg veins failing to efficiently drain the blood from the legs. The accumulation of extra blood in the legs leads to vein distension and the leakage of fluid from the veins into the surrounding tissue. This leads to symptoms and signs of CVI which include, in part, the following: 1) leg heaviness or calf ache after standing or sitting for prolonged periods, 2) swelling of the ankle and/or calf, 3) varicose veins which are large, visible veins under the skin, 4) venous ulcers, and 5) bleeding veins in the legs. He/she has explained to me that the superficial vein ablation technique closes the superficial vein so that the leaking valves no longer exist. The blood from the closed vein is rerouted to the deep veins.

Procedure: The ablation technique involves placing a needle and catheter into the superficial vein under sterile conditions. Local anesthesia is used to numb the skin so that placement of the catheter does not hurt. The catheter is positioned near to where the superficial vein empties into the deep veins. The area around the treated vein may require additional injections of a liquid preparation called tumescent anesthesia which both numbs the nerves around the vein and collapses the vein around the catheter. The radiofrequency and laser techniques then “close” or ablate the vein using heat to damage and occlude the inside of the vein.

Treatment Options: There are generally no major risks if I elect not to have treatment. I am aware that alternative treatments exist and can include no treatment, compression, surgery to remove the veins, and Sclerotherapy (chemical ablation).

Risks: I have also been advised of the risks of this procedure which may include:

1. Failure to close the vein or the vein later reopening
2. Leg swelling
3. Skin bruising / skin discoloration / scar formation at the insertion site
4. Inflammation of the treated vein with pain, tenderness and redness
5. Nerve injury with temporary or permanent numbness or tingling in the leg
6. Skin burns that may need to be treated with additional surgery
7. Infection / bleeding
8. Deep vein thrombosis and/or pulmonary embolism (clot in a deep vein and/or lung)
9. Rarely, injury of the artery causing decreased blood flow to the leg

Benefits: Dr. _____ has explained to me the benefits of this treatment, namely improvement or resolution of the signs and symptoms listed above. He/She has also explained that if I choose to not treat my condition, I may or may not have progression of symptoms and tissue damage in my leg (s) and that the condition has the potential to make my leg(s) worse over time.

He/she has not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent for treatment.

- I do consent to the taking of photographs/videos for use regarding my care as well as for educational or scientific purposes.
- I do **NOT** consent to the taking of photographs/videos for use regarding my care as well as for educational or scientific purposes.

PATIENT SIGNATURE

WITNESS

PRINT NAME

DATE OF BIRTH

I have informed the patient of the available alternatives for treatment of the superficial leg or saphenous veins, and of the potential surgical risks, complications and results that may occur as a result of it.

PHYSICIAN

DATE