THE VEIN CENTER OF CINCINNATI

CONSENT FOR TREATMENT

Endovenous Ablation (EVLT & RF)

Patient Name: _____ Date of Birth _____

I consent to have an Endovenous Ablation treatment procedure performed by The Vein Center of Cincinnati for the purpose of closing my varicose veins.

IMPORTANT: Prior to any procedure, please confirm you are not pregnant or breast feeding. Please review your history of heart rhythm problems and / or drug allergies with the medical provider.

I have read and understand the following information:

1. This procedure is performed by introducing a catheter through my skin under local anesthesia into an abnormal vein for the purpose of closing the vein.

2. Though rare, as with any procedure that may benefit a patient, there are risks involved. General risks for any procedure and risks associated with this procedure are as follows:

    a. There is a risk of thermal injury (burn) to the skin surface. This is minimized by the use of local anesthesia and examination of proper catheter placement using ultrasound. It is a rare occurrence.

    b. There is risk of nerve injury. The nerve is in close proximity to the vein. This can cause a loss of feeling in the treated part of the leg but no loss of motor function. This is generally temporary and improves with time.

    c. There is risk of a clot forming in the vein and a condition known as phlebitis, which causes the vein to become inflamed and sore. Phlebitis is temporary and may be a part of the normal process in which the vein closes down. Clots in surface veins generally do not pose a health threat. Clots in deep veins are extremely rare as deep veins are not treated by this technique and compression stockings and walking will minimize the risk of a deep vein clot. However, clots in deep veins when they do occur, can cause serious health threats, including pulmonary embolism and death. These more serious occurrences are usually associated with surgical procedures and situations where the patient is immobilized for long periods of time. Significant clots may require hospitalization.

    d. As with any procedure in which the skin is punctured, there is a risk of infection. This is minimized by using careful sterile technique. Infection can be treated with antibiotics, but severe infections occasionally may require hospitalization.

e. As with any procedure that involves puncturing the skin and puncturing a blood vessel, there is a risk of bleeding. Bleeding from veins will almost always stop with pressure, but occasionally, a small incision will be needed in order to tie the bleeding vein with a ligature. If severe bleeding should occur (extremely unlikely), hospitalization and blood transfusion may be required. Risks associated with blood transfusions are: allergic (immune type reactions), infections such as hepatitis and HIV. The risk of infection is very rare due to modern screening techniques.

f. There is a risk of allergic reaction to the local anesthesia.

g. I understand there are other alternatives to the Endovenous Ablation procedure, wearing compression stockings or choosing no treatment at all.

h. I understand that all the symptom of various veins may not be immediately or completely eliminated by this procedure, but that it is necessary in order to stop the backward flow of blood through a vein that is not working properly. I further understand that follow-up treatment in the form of sclerotherapy or possibly a phlebectomy of any remaining veins, especially below the knees, may be necessary following this procedure.

Photographs: I consent to being photographed before, during, and after the treatment. These photographs shall be the property of this medical practice for treatment purposes.

Patient Initials: _____

I consent to allow this medical practice to use photos without referring to my name to use for publication and marketing materials.

_____**Yes** _____**No** **Patient Initials:** _____

INFORMED CONSENT ACCEPTANCE

By signing below, I acknowledge that I have read the foregoing informed consent form and that I understand the risks of Endovenous Ablation treatment, alternative methods of treatment, and the risks of not treating my condition, and I hereby consent to vein treatment.

Patient Name: _____

Patient Signature: _____ **Date:** _____

TVCC Provider Name: _____

TVCC Provider Signature: _____ **Date:** _____