



Consent for Treatment: Ambulatory Microphlebectomy Procedure

Patient Name: _____

Date of Birth: _____

1. Nature of the Procedure

Ambulatory microphlebectomy is a minimally invasive procedure for the removal of varicose veins. The treatment involves making small incisions to extract the affected veins using specialized hooks. It is performed under local anesthesia, and the patient is typically able to walk immediately following the procedure. Compression stockings are usually recommended post-procedure to support healing.

2. Purpose of the Procedure

The primary goal of this procedure is to:

- Remove varicose veins that cause discomfort, swelling, or cosmetic concerns.
- Improve symptoms such as leg pain, heaviness, and cramping associated with varicose veins.
- Enhance the appearance of the treated area by removing visible varicose veins.

3. Risks and Potential Complications

As with any medical procedure, there are risks involved. While ambulatory microphlebectomy is considered safe, complications can occur, including but not limited to:

- **Bruising and Bleeding:** Temporary bruising is common and typically resolves within a few days.
- **Infection:** Although rare, infection can occur at the incision sites.
- **Scarring:** Small scars may form at the incision sites, which usually fade over time.
- **Nerve Injury:** There is a risk of temporary or permanent numbness or tingling near the treated area.
- **Swelling:** Some patients may experience swelling or fluid retention after the procedure.

- **Pigmentation Changes:** Skin discoloration at the treated area is possible and may persist for several months.
- **Deep Vein Thrombosis (DVT):** A rare but serious risk involves the development of blood clots in deeper veins.
- **Recurrence of Varicose Veins:** New varicose veins may develop over time even after successful treatment.

4. Alternatives to Microphlebectomy

The following alternative treatments have been explained to me, and I understand that I may choose one of these options or opt for no treatment at all:

- Compression therapy (e.g., wearing compression stockings)
- Sclerotherapy (injection of a solution to collapse the vein)
- Endovenous laser therapy (EVLT) or radiofrequency ablation (RFA) (using heat to close off the vein)
- Observation (no treatment)

5. Expected Benefits

The benefits of ambulatory microphlebectomy include:

- Removal of unsightly varicose veins.
- Relief from symptoms such as pain, swelling, and heaviness in the legs.
- Potential improvement in skin appearance and leg function.

I understand that the outcomes of this procedure may vary, and no guarantees have been made regarding the success of the treatment or the complete resolution of symptoms.

6. Post-Procedure Care

I understand that I will need to follow specific post-procedure care instructions, which may include:

- Wearing compression stockings as advised by my physician.
- Walking regularly to promote blood circulation.
- Avoiding strenuous activities for a specified period.
- Attending follow-up appointments to monitor healing and the success of the procedure.

7. Patient Responsibilities

I understand that my responsibilities include:

- Providing my healthcare provider with accurate information about my medical history and current medications.
- Informing my physician if I have any allergies, particularly to medications or anesthetics.
- Following the pre- and post-procedure care instructions as provided by my healthcare provider.
- Reporting any unusual symptoms, such as excessive pain, redness, or swelling, immediately after the procedure.

8. Consent

By signing this form, I acknowledge that I have read and understood the information provided about the ambulatory microphlebectomy procedure. I understand the risks, benefits, and alternatives, and I have had the opportunity to ask questions. My questions have been answered to my satisfaction.

I consent to undergo the ambulatory microphlebectomy procedure as recommended by my healthcare provider. I understand that I have the right to refuse treatment at any time before the procedure.

Patient Signature: _____ **Date:** _____