



TOTAL VEIN CONCEPTS



Greenbrier Healthplex
713 Volvo Parkway, Suite 105 ♦ Chesapeake, Virginia 23320
Phone (757) 282-4045 ♦ Fax (757) 282-4030

CONSENT FOR AMBULATORY PHLEBECTOMY

Patient Name: _____

Date: _____ Time: _____

- _____ **A. Nature and Purpose of Vein Surgery**
I hereby authorize _____ and/or associate to extract, contact, or interrupt diseased veins for the purpose of attempting to improve the symptomatology and/or appearance for my legs.
- _____ **B. Alternatives**
I understand that alternative treatments for varicose veins exist including conservative treatments (elastic stockings), sclerotherapy injection of sclerosing agents into diseased veins, stripping, and vein ligation.
- _____ **C. Risks**
The nature of the procedure to be performed has been explained to me, and I understand that among the known risks are bruising, swelling of the leg, transitory pigmentation, scarring, keloid, dermatitis, and secondary telangiectasias (spider vein).

I am aware that in addition to the minor risks specifically described above, there are other risks that may accompany any surgical procedure, such as loss of blood, infection, inflammation in the venous systems with formation of a thrombus (clot), postoperative bleeding, and nerve trauma which may lead to temporary numbness.
- _____ **D. Anesthesia**
I consent to the administration, to be administered by _____ or under his/her direction. I am aware that risks are involved with the administration of local anesthesia, such as allergic or toxic reactions to the anesthesia and cardiac arrest.
- _____ **E. Proposed Treatment**
I know that the practice of medicine and surgery is not an exact science, and, therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone, as to the results that may be obtained.

I have had sufficient opportunity to discuss my condition and proposed treatment with _____ and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent to the proposed treatment.

I hereby authorize _____ to perform any other treatment that may be deemed necessary, should he/she encounter an unhealthy or unforeseen condition during the course of the procedure.

_____ **F. Cooperation**
I agree to keep _____ and staff informed of any changes in my permanent address, and I agree to cooperate with them in any after care.

_____ **G. Photographs**
I consent to be photographed before, during, and after the treatment that these photographs shall be the property of _____ and may be published in scientific journals and/or shown for scientific reasons.

_____ **H. Informed Consent**
I certify that I have read the above consent for surgery permit. It has been fully explained to me, and I fully understand the above consent for surgery permit. I fully understand the inherent potential risks, complications, and results of both the surgical procedure and necessary anesthetic that were made known, and I accept full responsibility for these or any other complications that may arise or result during the surgical procedure(s), which is to be performed at my request according to this consent and surgical permit.

PLEASE INITIAL EACH PARAGRAPH AND SIGN BELOW

Patient (or Legal Guardian)

Relationship to Patient

Patient Name (please print)

Witness

I certify that I have informed the patient of the available alternative(s) with respect to the proposed surgical procedure and of the inherent potential surgical risks, complications, and results that may occur as a result of said procedure.

Signature of Doctor