Consent for Sclerotherapy of Varicose and Spider Veins

I hereby authorize Dr. Surya Challa and associates/assistants and other healthcare providers he/she deems necessary, to treat my spider veins/varicose veins using sclerotherapy. I understand that my condition is not life or limb threatening. I also recognize that venous disease is a chronic disorder, and that new vein problems may develop over time, which may require further treatment.

Procedure: Sclerotherapy is the injection of medication ("sclerosant') via a needle into unwanted veins. The goal is to irritate and scar the veins from the inside such that these abnormal veins close and no longer fill with blood. Several treatments are usually required to obtain maximum improvement.

Treatment Options and alternatives: 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 therapy, surgery to excise the veins, and ablation with laser or radiofrequency.

Risks: There are risks and hazards related to the performance of sclerotherapy planned for me. I realize that complications can occur and include but are not limited to those listed below:

1. Brownish discoloration. This is not uncommon but is usually temporary. It could take several months or longer to resolve. It is uncommon for discoloration to be permanent. ____ (**initials)**

2. Clusters of spider veins (telangiectatic mattes). These small veins often resolve spontaneously, may need treatment in an attempt to clear them, and could be permanent even with treatment. ____

3. Bruising is common and typically resolves over a few days to weeks. ____

4. Blistering, redness, itching, irritation, swelling or pain can occur but are usually temporary. ____

5. Infection is rare ____

6. Ulceration and scarring occur rarely. ____

7. Allergic reactions are rare. They range in severity from mild to life threatening reactions. ____

8. Inflammation around a vein can occur. This may be tender but generally resolves with treatment. Tenderness, bruising or firmness in the treated area can occur and may be long lasting but rarely permanent. ____

9. Deep vein thrombosis (blood clots) and pulmonary embolism (clot in the lungs) are rare. ____

10. Injury to a nerve, causing either prolonged or permanent discomfort, numbness or difficulty walking is very rare. ____

11. An arterial injection can occur very rarely. Consequences range from discomfort, scarring of the skin, injury to muscle or nerves or other tissue, or loss of limb. ____

12. Other side effects are possible although uncommon. ____

Benefits: This procedure may decrease discomfort and other symptoms from leg veins, and may provide an improved cosmetic appearance.

PATIENT SIGNATURE (please acknowledge each paragraph with a check mark)

By my signature below, I acknowledge that I have read and received a copy of the Sclerotherapy information form and a copy of the Informed Consent for Sclerotherapy Form ☐

I certify that this information has been explained fully to me, that I have read it or have had it read to me, and that I understand its contents. I voluntarily consent to this procedure. ☐

I have been adequately informed of the risks, benefits, and alternative methods of treatment as well as the risks of not treating my condition. ☐

I have discussed and have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved. I believe I have sufficient information to give this informed consent. ☐

I authorize the taking of clinical photographs which may be used to counsel other patients or for marketing, educational and scientific purposes. ☐

I am aware that no available treatment for spider, reticular and/or varicose veins is successful 100% of the time. Multiple treatments may be required. Treated veins may fail to close, or may close and then re-open. Additional or alternative treatments may be required. Results are not guaranteed. ☐

I hereby consent to proceed with Sclerotherapy treatment. ☐

_____ _____

Signature (Patient or Patient Guardian) **Print Name Relationship** **Date**

WITNESS OF PATIENT'S SIGNATURE

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. The patient was given an opportunity to ask questions. All of the patient's questions were answered to their satisfaction.

_____ _____ _____

Witness Signature **Print Name, Title** **Date**