Vein Specialists

ENDOVENOUS ABLATION INFORMED CONSENT

Patient Name: _____Date of Birth:_____Date:_____
(please print)

Procedure by: Dr. Magnant
Diagnosis: Venous Insufficiency of the Saphenous Vein(s)
Pre-medication taken:_____Time Taken:_____

First Procedure:
☐**Right** ☐**Left** ☐**Bilateral**
☐**Radiofrequency Ablation of the:**
☐**LASER ablation of the:**
☐**VenaSeal™ ablation of the:**
- ☐**Great Saphenous Vein**
- ☐**Small Saphenous Vein**
- ☐**Anterior/ Posterior Saphenous Vein**
- ☐**Branch**

☐**Microphlebectomy**

Second Procedure:
☐**Right** ☐**Left** ☐**Bilateral**
☐**Radiofrequency Ablation of the:**
☐**LASER ablation of the:**
☐**VenaSeal™ ablation of the:**
- ☐**Great Saphenous Vein**
- ☐**Small Saphenous Vein**
- ☐**Anterior/ Posterior Saphenous Vein**
- ☐**Branch**

☐**Microphlebectomy**

Nature and purpose of the procedure: The application of radiofrequency or LASER energy through an endovascular probe (inside the vein) to seal the vein shut and stop the venous reflux. Removal of varicose veins through small incisions.

Material risks of procedure include: hematoma, infection, severe loss of blood, disfiguring scar, tissue loss, allergic reaction, cardiac arrest or death. Other risks include inability to meet cosmetic goals and additional procedures may be necessary.

1. Failure to improve symptoms or resolve varicose veins
2. Failure of vein to remain closed
3. Leg swelling
4. Bruising
5. Mild Phlebitis (pain, tenderness, redness over the treated vein or associated varicose veins)
6. Numbness
7. Tingling or Paresthesias in treated leg
8. Skin burns that may need treatment
9. Deep Venous Thrombosis (DVT) which may lead to Pulmonary Embolism (PE) which may be fatal

Practical alternatives to procedure:

1. Venous ligation (cutting and tying the vein closed);
2. Vein stripping (pulling a long segment of the vein out of the body);
3. Compression stocking therapy
4. Sclerotherapy (injecting a chemical to irritate and occlude the vein);
5. Other methods listed above to seal vein with heat or medical adhesive.

Patient's Initials:_____

If I choose not to have the above recommended procedure, I understand that my condition, signs and symptoms will not likely substantially improve and will likely progress over time.

Consent: The procedure identified above has been explained to me, the material risks, alternatives and benefits have been described, and all of my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure by Dr. Magnant.

Type of anesthesia: ☐ Local ☐ Local w/ Oral Sedation

I realize that during the procedure the physician/surgeon may become aware of conditions which were not apparent before the start of the procedure. If unforeseen conditions arise in the course of the procedure calling in his judgment for procedures in addition to or different from those contemplated, I further request and authorize him to do whatever he deems is advisable to diagnose or treat such conditions.

In the event of a medical emergency, I acknowledge that I may be transferred by ambulance to a hospital with whom Vein Specialists has an existing transfer agreement.

I consent to an outside visitor(s) to be present in the procedure room for observation purposes (i.e., a representative of an equipment company, physicians, students, etc.).

In the event of a bloodborne pathogen exposure, I consent to, at no cost to me, an oral/blood test for HIV and a blood draw for Hepatitis B and C.

Vein Specialists is a physician's office and is regulated pursuant to the rules of the Board of Medicine of the State of Florida as forth in Rule Chapter 64B8, FAC.

❑This consent has been translated to me in Spanish. I, the patient, have had the opportunity to ask questions and wish to proceed with the planned procedure. Translator's name:_____

❑ I have read and understand my pre/post-op instructions. Patient's initials:_____

❑ I, _____, the patient, understand the risks, alternatives and benefits of the planned procedure and wish to proceed at this time. *(patient to fill in their name)*

❑ I, _____, responsible adult to the patient, confirm the patient is of sound mind and is fully capable to consenting to the proposed procedure. *(respon. adult to fill in their name)*

_____
Print patient name or authorized person

_____ _____ _____
Patient signature or authorized person Date Time

_____ _____ _____
Witness Date Time

_____ _____ _____
Signature: Dr. Magnant Date Time

Form date: 8/4/2022