Informed Consent for Varithena ™(Polidocanol)

PLEASE DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT OR HAVE HAD ADEQUATE EXPLANATION AND AGREE TO THE PERFORMANCE OF THE PROCEDURE.

THE FOLLOWING HAS BEEN EXPLAINED TO ME IN GENERAL TERMS AND I UNDERSTAND THAT:

1. The diagnosis requiring this procedure is varicose veins and/or residual leaky saphenous veins.
2. The nature of the procedure is injection of a foam based sclerosant solution into the veins to close the veins.
3. The purpose of this procedure is to scar the veins and relieve the pain, swelling or inflammation associated with the veins. I understand that Varithena is FDA approved and that it may take some time (up to 3-6 months in some cases) to realize the full benefit from the procedure.

RISKS OF THIS PROCEDURE

As a result of this procedure being performed there may be risks of: thrombosis or clots, bruising, failure of the veins to close and inflammation over the treated veins.
Other risks include: allergic reaction including anaphylaxis, mini stroke or stroke and possible cardiac arrest.

Practical alternatives to this procedure include: Compression Stocking Therapy.

If I choose not to have the above procedure, I will likely continue to experience the symptoms I presented with and the condition may progress over time.

I understand that Dr. Magnant and other assistants will rely on statements about myself, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been fully explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure. Dr. Magnant or his assistants have explained the number of sessions I will be scheduled for. I also understand I may choose to have additional sessions of cosmetic sclerotherapy to treat residual spider veins or reticular veins at my expense. I also understand that vein disease cannot be “cured” and often requires ongoing maintenance therapy, the interval and nature of which are impossible to predict.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME; THAT I FULLY UNDERSTAND IT CONTENTS; THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY; ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF HAVE BEEN CROSSED OUT BEFORE I SIGNED THIS FORM.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Magnant and any other physicians or other medical personnel who may be involved in the course of my treatment.

_____ _____

Patient Signature Date

_____

Patient Name (print)

_____

DOB

_____

Signature of Guardian or Power of Attorney

Patient unable to sign because of:

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WITNESS

PLEASE NOTIFY THE OFFICE 24HRS PRIOR TO CANCELLING OR RESCHEDULING YOUR APPOINTMENT. FAILURE TO DO SO MORE THAN 24HRS IN ADVANCE (unless it is an excused emergency) MAY RESULT IN **A $90.00 CANCELLATION FEE.**