



SAMPLE

Consent for Injection Treatment of Varicose Veins

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form will acknowledge your consent to treatment recommended by your physician.

Explanation: You have been scheduled to have an injection treatment of varicose veins. (Injections, sclerotherapy).

Technique: The skin will be cleansed with an antiseptic solution, usually alcohol, to kill surface bacteria. A needle will be inserted and a small amount of sclerosing solution will be injected. The solution may not have a formal FDA approval for this application at this time.

Alternatives: These may include the use of compression stockings or the surgical alternative of GSV (vein stripping) if the surgeon determines you would be a good candidate for this.

Risks: As with any procedure, there are potential risks. Your physician has scheduled you for this study and believes the potential benefits outweigh the risks.

The risks of this procedure include, but are not limited to the following: skin discoloration, skin breakdown in or near the injection site, bleeding, deep vein thrombosis (blood clots causing swelling of the leg, ankle, and foot) which very rarely result in life threatening complications, infection within the skin, inflammatory reaction resulting in redness and swelling of the area, nerve trauma, allergic reaction to the injected substance, and very rarely permanent dysfunction or disability or death.

Although these risks and complications rarely occur, they do sometime occur and cannot be predicted or prevented by the person performing the procedure. Most procedures have good results, but there is no guarantee regarding the results of this procedure.

Please notify the surgeon if you have a history of prior allergic reaction, history of bleeding disorders or are on medications that thin the blood.

I have read the above or have had it read to me. I understand the information given to me. My questions have been answered to my satisfaction.

I wish the procedure to be performed.

I do not wish to have the procedure performed. I understand I should discuss my decision with my physician.

For a complete record of my case, I give consent to the taking and reproduction of photographs which will show the areas being treated. Furthermore, I consent to the showing of such photographs to professional groups for their instruction, or to lay individuals so that they can learn about the conditions which are treated and the results of such treatment. Consent for this is given with the understanding that my case will not be identified, nor will my name be used or revealed at any time.

Signed: _____ Date: _____ Time: _____ A.M. P.M.

Signature of Patient or Legal Representative

Relationship to Patient: _____

Witness: _____