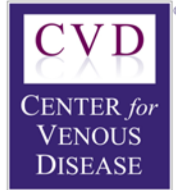
Patient:________________________ MR#__________________________
DOB:__________________________DOS__________________________

Patient Consent Form-Addendum to State Required Consent(s)



CVD® has a great deal of experience with venous disease and we strive to provide our patients with the desired results. However, there are issues, concerns, and risk associated with any medical procedure. Therefore, a signed CVD Patient Consent Form is necessary for any treatment at our centers. Thank you!

Today's Procedure(s)

- ☐ **VNUS® Closure RF Ablation/ GSV-SSV-RFS**
- ☐ **Ambulatory Micro Phlebectomy**
- ☐ **Sclerotherapy**

VNUS CLOSURE*FAST*® PROCEDURE-

I hereby authorize ______________________ to close my venous insufficient refluxing vein(s) using an endovenous radiofrequency obliteration technique, also known as the VNUS Closure® procedure. CVD utilizes the ClosurePlus, ClosureFast, RFS Stylet. He has explained that the device used to perform this procedure is known as the VNUS Closure System; it is a commercially available product used specifically for this purpose. I understand that alternative treatments for obliterating the function of the saphenous vein include ligation (cutting or tying the vein in the groin or behind the knee), stripping the vein (pulling a long segment out), or compression sclerotherapy (injecting a chemical to occlude the vein). The doctor(s) have explained that common symptoms of varicose veins, such as heaviness and pain after standing for a long time, arise from malfunctioning valves in the saphenous vein (the main external vein in the thigh and calf). The resulting increased pressure in the saphenous vein is transmitted to my varicose veins. Satisfactory treatment of varicose vein symptoms is usually achieved by obliterating the saphenous vein. Although closure of the saphenous vein using the VNUS Closure System should reduce the pressure in my varicose veins and thus relieve many of my symptoms, I understand this consent for the VNUS Closure procedure for treatment of my saphenous vein does not include actual removal of the varicose veins, which may still be visible.

INT._____

AMBULATORY MICRO PHLEBECTOMY- (Separate Consent Form Needed)

Ambulatory or "stab" micro phlebectomy might be utilized in conjunction with the VNUS Closure procedure or as a stand alone medical procedure to remove unwanted cosmetically warranted bulging veins. The area is prepped, sterilized, and draped. The marked area is then injected lidocaine to anesthetize the area of treatment. AP is a procedure whereby small (1-2mm) incisions or an 18 gauge needle is used to open the skin so that specialized instrumentation (phlebectomy Instruments) can be inserted through this opening. The veins are removed through the tiny opening. Compression is applied over the site and wrapped as directed.

INT._____

SCLEROTHERAPY- (Separate Consent Form Needed)

Sclerotherapy might also be used to inject smaller unsightly veins for the needed cosmetic effect. Sclerotherapy utilizes a FDA approved substance to irritate and destroy the diseased vein(s). Both micro

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phlebectomy and sclerotherapy have risk factors associated with them and will be discussed. The treatment timing of these adjunctive procedures will also be discussed.

INT._____

DISCLOSURE OF RISK-

The general nature of the procedure(s) for treatment of the vein incompetence has been explained to me. I understand that among the known risks of this procedure is failure to close or meet the desired cosmetic result of the treated vein. Leg swelling, mild bruising, mild phlebitis (pain, tenderness, redness) over the treated vein, numbness and tingling in the treated area, and small irritated skin abrasions or blisters that may need to be treated with additional treatment. In addition; blood clots in veins or lungs, pulmonary embolism as a result of blood clots, skin slough, allergic reactions, or recurrence of varicose veins may occur. These complications are rare in an office setting but might occur.

INT._____

I am aware that in addition to the risks specifically described above, there are other risks that may accompany any surgical procedure, such as intra- and post-procedure blood loss, infection, and clot formation in the venous system.

INT._____

Doctor(s) have not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment with my physician and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent for treatment(s).

INT._____

In addition, I agree to disclose any legal action I have made against any and all health care providers, hospitals, surgery centers, clinics, laboratories, etc… to the treating physician regardless of when the action was taken or when it occurred.

I further understand that I will leave the facility after treatment(s) with a compression wrap over the treated limb. This wrap can be removed by you after 48 hours from treatment or to remain in place as directed by the doctor. Compression stockings must be worn for 2 weeks, during the day only, post procedure or as directed. Your post-procedure instructions will be discussed with you and you will receive these instructions in writing. These recommendations must be followed.

From time to time, other medical staff observers may be present. You have the right to refuse visitor observation. Every attempt to protect your privacy will be made by the CVD as dictated by HIPAA Privacy Standards.

Patient Name (printed)______________________________________

_______________________________ _______________________________ M.A.
Patient Signature Witness

I have informed the patient of the available treatment options for the treatment of venous disease, and of the potential procedure risks, complications and results that may occur as a result of it.

______________________________ _______________________________
Physician Signature Date

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