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Endovenous Laser Therapy CONSENT FORM

Please read and initial each statement.

I have read and understood the **Endovenous Laser Therapy Information and Treatment Instructions** and have had an opportunity to ask questions that have been satisfactorily answered. _____

I authorize the physician to perform Endovenous Laser Therapy on me. _____

The cost of treatment has been discussed with me and I agree to pay \$_____.
A \$500 non-refundable deposit is required at the time of booking the procedure and the balance is due 1 week prior to the procedure. Up to 2 sessions of regular sclerotherapy will be included at no extra charge if varicose veins persist. Further treatment of other veins may be required at an additional costs. _____

I understand:

- the goal of EVLT is to close off refluxing dilated veins and most often this is the great saphenous vein. Other dilated veins present may improve as well or they may require additional treatment. Every individual is unique which makes it difficult to guarantee a specific response. Results vary with the individual depending on underlying vein issues that may not be present at this time. Rarely EVLT will not be successful and may require a repeat treatment or an alternative treatment. There may be additional costs for re-treatment. I may require additional treatments such as sclerotherapy. _____
- side effects and risks discussed in the **Endovenous Laser Therapy Information and Treatment Instructions** may occur. If these complications occur they are usually temporary but some may permanent. There may be risks not yet known at this time. _____
- there may be an increased occurrence of side effects if I do not follow the pre- or post-procedure instructions or if both legs are treated at one time. _____
- EVLT is not recommended if you are pregnant, breastfeeding, have active infection at the site, have had a recent blood clot in your legs or lungs/are prone to blood clot formation, have an unstable medical condition or are not _____

able to regularly ambulate. None of these conditions apply to me or if they do, I know that I am at an increased risk of suffering complications.

- EVLT is not recommended if you are planning to travel within 1 month before or after the procedure. _____
- there are other options for treatment including surgery such as stripping or ligation and I have had an opportunity to discuss these including not having EVLT. _____
- **eye damage** may occur if protective eyewear provided is not worn. _____
- the risk of side effects increases with other medical situations such as immunodeficiencies (diabetes, HIV, smoking, being on immune suppressants such as prednisone) that can be associated with poor skin healing and increased risk of infection. None of these conditions apply to me or if they do I am at an increased risk of suffering complications. _____
- I am required to purchase a pair of 30-40mmHg compression stockings, a second pair is recommended. _____
- I should call the clinic if I have any questions or concerns about my treatment. I will notify the clinic if I experience any complications as soon as possible. _____
- I should follow up at the clinic within **1 month** of the procedure. _____

I authorize the taking of clinical photographs for:

- my clinic record _____
- research and education (discretion applied) _____
- publication _____
- the U Cosmetic website (discretion applied) _____
- the U Cosmetic Brag Book kept in the clinic (discretion applied) _____

I have read and understand this **EVLT Consent Form**. My questions have been answered satisfactorily by the doctor or nurse. I accept the risks and complications of the procedure.

Patient name (please print) Date Signature

Witness name (please print) Date Signature

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