Patient Informed Consent for EVLA/RFA

Endovenous Laser Ablation/Radiofrequency Ablation

I _____ (patient or guardian) authorize Dr. _____ and associates to perform the following procedure; Endovenous Laser Ablation/ Radiofrequency Ablation of my (circle which applies) right/ left * greater/ lesser saphenous vein, right/ left * anterior/ posterior greater saphenous vein.

Endovenous Laser Ablation/ Radiofrequency Ablation (EVLA/RFA):

I understand this means that the physician, using ultrasound for guidance, will direct a catheter and subsequently a laser fiber, into the incompetent vein from a point below the groin up towards the groin area. I understand that once the laser fiber is positioned and anesthetic is injected around the vein, that he will activate the laser and pull all of the components down the inside of the vein, closing the vein with heat energy.

I understand that the reason for this procedure is to correct my venous insufficiency caused by reflux, or backward flow, of blood down my leg. I understand there are alternatives to the procedure(s), and they have been explained to me. These procedures include surgical stripping and ligation, Radiofrequency ablation, and Ultrasound Guided Sclerotherapy. Despite the alternative, I consent to the EVLA/RFA procedure understanding that there are risks with any invasive procedure. I also understand that despite the clinical efficiency of the EVLA/RFA procedure, my physician cannot make any guarantees about my results or cure of my venous disorder.

These risks have been thoroughly explained to me, and include but are not limited to; infection, scarring, allergic reaction to medications, nerve injury (paraesthesia), clot in the deep vein (DVT- Deep Vein Thrombosis), thermal injury (burn), pigmented on the skin over the vein area and bleeding. I understand that there may be some mild side effects including bruising, pain, or a tightening, pulling sensation in the thigh, leg, palpable lumps and/ or hematomas (bleeding) that may need aspiration to relieve, ankle swelling.

Consent: These issues have been reviewed with me, and I have read and fully understand this consent forms. By signing, I acknowledge that I have no further questions and consent to proceed with the EVLA/RFA procedure.

Printed Patient Name: _____

Patient/ Guardian Signature: _____ **Date**: _____

Physician Signature: _____ **Date**: _____