

Vein & Laser Center of New England

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Informed Consent for Laser Vein Closure & Microphlebectomy

Please read carefully before signing

I understand that I will be undergoing laser closure of selected veins in my lower leg. (Please fill in side to be operated on): _____. The details of the procedure have been fully explained to me. I feel I have been given the time to ask any questions and express concerns. I realize that for technical reasons the procedure may not be able to be performed as planned.

I also understand that no single procedure will necessarily get rid of all my visible veins and that staged procedures may be necessary.

Following laser closure, I **may** also undergo small incisions in my leg to remove the more prominent veins.

I understand that the following complications may occur:

- Deep venous thrombosis - very uncommon but could necessitate hospitalization and use of blood thinners.
- Superficial clot formation- common, self limiting. No significant risk.
- Skin bruising and discoloration - very common, self limiting
- Skin ulcerations- 2-4%. Could necessitate debriding of wound and topical ointment therapy
- Bleeding- uncommon. May mean suturing of wound, or reapplying dressing. Could result in an Emergency Room visit. Small possibility of hospital admission
- Infection- not uncommon. Usually self limiting and treated with oral antibiotics
- Nerve injury- uncommon. Would result in "burning" or numb feeling in a localized area of the leg. Usually resolves after several months but could be permanent.
- Pigment staining of the skin - not uncommon, usually resolves with time.
- Allergic reaction to medications- uncommon. Potentially life threatening but extremely rare.

Prior to the procedure, please inform the staff of any medication or iodine allergies even if mentioned at the time of previous visits

- Pain and discomfort -varies in each individual. Most patients tolerate the procedure extremely well.

I understand that there is a 95% closure success rate with the use of the laser. However, if unsuccessful, the procedure may need to be repeated or other interventions performed.

I agree to wear the compression dressings and stockings as directed and realize that compliance to instructions significantly affects the results of the procedure.

I agree to return for follow up examinations especially ultrasound studies to assess the adequacy of the procedure and help diagnose any potential problems.

Patient signature _____ Date _____

Physician signature _____ Date _____

Witness _____ Date _____