Telephone (302) 731-0001
Fax (302) 731-0040

**Patient Consent for Sclerotherapy Treatment**

I,___________________________understand that medicine is not an exact science, and that even though the vast majority of patients are satisfied with their results, there is no guarantee I myself will be satisfied with the improvement in my varicose veins after treatment. I acknowledge that the following topics have been explained to me, and that I understand the explanations I was given. I have had the opportunity to ask any questions. In particular, I am familiar with the following included, but not limited to:

- The various techniques that can be used for treating diseased veins
- The option to do nothing about my vein problem
- Benefits of treatment
- Risks & potential complications
- Bruising & discoloration
- Inflammation or trapped blood
- Fainting from nervousness
- Allergic reaction to medication or tape
- Skin staining (hypopigmentation)
- Skin ulcers
- Telangiectatic matting
- Recurrence of varicosities
- Theoretical risk of thrombosis, embolism and death

I recognize that even though any particular problem may be extremely rare, it is always possible that any patient may have one of these problems. I accept that possibility for my own treatment.

I understand that ultimately I am responsible for my own medical bills. I understand that unless otherwise in writing, I must pay my bill in full at the time of each visit. If this medical practice agrees to accept initial insurance assignment for some portion of my medical care, I authorize this medical practice to submit bills to my insurance company and to receive reimbursement directly from my insurance company.

Patient Signature: ______________________________________________ Date: ______________________

Witness:_______________________________________________

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Sclerotherapy

Patient Name: ______________________________________Date: ___________________

D.O.B: ____________________________________________

THE PATIENT RECEIVED FULLY INFORMED CONSENT WITH THE RISKS, COMPLICATIONS, BENEFITS AND ALTERNATIVE PROCEDURES. SPECIFICALLY, THE PATIENT WAS INFORMED ON INFECTION, SENSORY AND MOTOR NEUROPATHY- TEMPORARY/PERMANENT AND COSMETIC CHANGES.

THE PROCEDURE TOOK PLACE AFTER THE **RIGHT/LEFT/BILATERAL** LEG(S) SPIDER VEINS WERE MARKED IN THE VERTICAL POSITION AND THE PATIENT WAS THEN PLACED ON THE TABLE.

NEXT STERILE PREP AND DRAPE WAS USED, ALCOHOL STICKS WERE USED TO PREP THE LEG(S)

THE PATIENT RECEIVED LASER MAPPING OF THE SPIDER VEINS AND THEN ADMINISTRATION OF 0.5%/1.0% ASCLERA INJECTED INTO THE SPIDER VEIN WITH THE RESULTING BLUSH OF CLEAR COLOR.

THE PATIENT RECEIVED ___________ VIALS OF SOLUTION AND WAS MADE TO WAIT FOR OVER 10 MINUTES POST PROCEDURE DUE TO THE POSSIBILITY OF ALLERGIC REACTIONS

THE PATIENT DID NOT RELATE ANY UNDUE DISCOMFORT OR ANY PAIN OR ANY MOTOR OR SENSORY CHANGES

THE WOUND WAS THEN DRESSED

THE PATIENT THEN RECEIVED DETAILED INSTRUCTIONS FOR CARE AND TO CALL US WITH ANY CONCERNS.

ANTHONY ALFIERI, DO, FACC

Telephone (302) 731-0001

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QUESTIONAIRE FOR FEMALE PATIENTS

**50 YEARS OF AGE AND UNDER**

Please answer ALL of the following questions:

Patient's Name:_______________________________________________________

1. Are you (check the appropriate box)
   - o Post- menopausal
   - o Pre-menopausal, surgically sterile. (E.g. hysterectomy, tubal ligation, etc.)
   - o Pre-menopausal, not surgically sterile. If so, are you or do you think you may be pregnant? (Please circle one)

   YES NO
2. The date of your last menstrual period was:__________________________
3. Have you ever had a mastectomy?

   YES NO
   - o Right
   - o Left
   - o Implant
   - o Prosthesis
4. Are you currently breast-feeding?

   YES NO

Patients Signature:______________________________ Date:____________