

## SCLEROTHERAPY

*Sclerotherapy is a remedy for removing spider veins. Spider veins are those red/blue/purple blood vessels found on the legs, near the skin surface. They are harmless but unsightly and can cause embarrassment. A solution (usually water or saline) is injected through a very fine needle into the vein. This produces irritation and inflammation inside the vessel causing the vein walls to stick together and close. Without a flow of blood through the vein, it will disappear within two to three weeks.*

Patient's  
Initials

- \_\_\_\_\_ I understand that multiple injections may be required to complete the treatment.
- \_\_\_\_\_ Details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- \_\_\_\_\_ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- \_\_\_\_\_ I understand and accept that the most likely material risks and complications of sclerotherapy have been discussed with me and may include but are not limited to:
- *bleeding*
  - *failed procedure*
  - *deep-vein blood clots*
  - *infection*
- \_\_\_\_\_ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- \_\_\_\_\_ I have informed the doctor of all my known allergies.
- \_\_\_\_\_ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol abuse.
- \_\_\_\_\_ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- \_\_\_\_\_ I am aware and accept that no guarantees about the results of the procedure have been made.
- \_\_\_\_\_ I have been advised of the probable consequences of declining recommended or alternative therapies.
- \_\_\_\_\_ I have been informed of what to expect after the procedure, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- \_\_\_\_\_ I understand that I must adhere to a strict schedule for wearing compression stockings, as ordered by my physician.
- \_\_\_\_\_ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct \_\_\_\_\_, M.D., with associates or assistants of his or her choice, to perform the sclerotherapy procedure(s) on \_\_\_\_\_ at \_\_\_\_\_ (name of facility) \_\_\_\_\_ (patient name).

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

*Continued*

12/02  
Revised 9/05, 12/05, 1/06, 6/07

*This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
initial      copy given to patient      Physician Signature/Date/Time      \_\_\_\_\_ original placed in chart  
initial

SAMPLE