



CONSENT FOR VARICOSE VEIN TREATMENT

Name of the patient : _____

A. CONSENT FOR THE PROCEDURE

1. I, the undersigned, hereby authorize Dr. _____ to perform the following procedure for treatment of varicose veins.
2. **Procedure name:** _____
3. **Specific location/side:** _____
4. I understand that I may need other additional procedures that were unexpected. I consent to the performance of any additional procedures determined during my initial procedure to be in my interest where delay might cause more harm.
5. I understand that my disease/condition is "varicose veins".
6. I have been explained in detail regarding my condition, treatment options available, expected results as well as likely complications associated with varicose veins and treatment.
7. I have also been explained about the conservative treatment option which includes stockings and medicines, but I choose to undergo this procedure for treatment.
8. I have understood the advantages, disadvantages, risks and benefits of the above-mentioned procedure. I know that there are risks for all types of surgeries or procedures. I have been informed about the side effects, including temporary pain and swelling, pigmentation, hardness and numbness at the site of the procedure. Other uncommon complications include ulcers, infection, bleeding, deep vein thrombosis and nerve injury.
9. I understand that for some kinds of medical equipments used during these procedures, a representative from the equipment manufacturer may also be present. Photographic documentation may also be performed.
10. I understand that varicose veins are known to re-occur due to a variety of reasons. Worldwide recurrence rates after treatment range between 5%–10%. The recurrence of veins would require another procedure to be performed.
11. By signing below, I acknowledge that I have read the foregoing information and understand the risks and possible side effects as well as alternative methods of treatment, and I here by consent to the treatment.
12. I know the practice of medicine and surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. While the overwhelming numbers of patients have noted gratifying symptomatic and cosmetic improvement, any specific result cannot be promised or guaranteed.

VARICOSE VEIN TREATMENT

Patient's Name: _____ **Patients' Signature:** _____

Relative's Name: _____ **Relative's Signature:** _____

Date: _____ **Place:** _____



B. CONSENT FOR ANAESTHESIA

1. I consent to the administration of local anesthesia as may be considered necessary by the doctor in charge of my care. I understand that the risks of local anesthesia include local discomfort, swelling, bruising and allergic reactions.

2. I also consent to the administration of sedative medications by the doctors or anaesthetist for the procedure to be performed. I have been explained that sedation would be given to reduce my discomfort during the procedure and that the possible side effects of such medicines nausea, vomiting, allergic reactions, changes in breathing or changes in blood pressure and heart function.

3. If spinal or general anaesthesia is to be given, apart from sedatives, I may also be administered anaesthetic agents. I understand that an endotracheal intubation or laryngeal mask airway would be utilized to maintain my airway and breathing and that the possible side effects include sore throat, hoarseness, vomiting, aspiration of stomach contents, muscle soreness, injury to teeth or gums, changes in breathing, changes in blood pressure and heart function.

By signing below, I state that I am 18 years of age or older and authorized to consent. I have read or have been explained the contents of this form and I agree to receive the care and treatment listed on consent. I have had a chance to ask questions and all of my questions have been answered.

Patient's Name: _____ **Patient's Signature:** _____

Relative's Name: _____ **Relatives's Signature:** _____

Date: _____ **Place:** _____

Declaration by the surgeon regarding the procedure

I hereby declare that I have explained in detail regarding the operative procedure and associated risk factors/complications. I have given detailed explanation to the patient and his/her relatives in a language they could understand and have given them opportunities to ask questions and have given satisfactory answers.

Patient's/Witness's Name: _____ Doctor's Name: _____

Patient's/Witness's Signature: _____ Doctor's Signature: _____

Date & Time: _____ Date & Time: _____

VARICOSE VEIN TREATMENT



This specific procedural consent is endorsed by the Vascular Society of India and may be used by vascular surgeons practising in India.