Patient Informed Consent for the Endovenous Laser Therapy (EVLT) Procedure

I _____________________ (Patient or Guardian) authorize Deemy Rekkas, Abbas Rampurwala, Ian Goldberg and Sumeet Sachdev, and assistants, to perform the following procedure: Endovenous Laser Ablation of the Right/Left Greater/Small Saphenous Vein.

I understand this means that the physician, using ultrasound for guidance, will direct a catheter and subsequently a laser fiber, into the damaged vein from a point distal to 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 the reflux, or backward flow, of blood down my leg.

I understand there are alternatives to this procedure, and they have been explained to me. These procedures include: Surgical Stripping and Ligation, radiofrequency ablation (VNUS) and Ultrasound Guided Sclerotherapy. Despite these alternatives, I consent to the EVLT procedure understanding that there are risks with any invasive procedure.

These risks have been thoroughly explained to me, and include but are not limited to; infection, bleeding, scarring, allergic reaction to medications, nerve injury (paresthesia), clot in the deep vein (DVT-Deep Venous Thrombosis), thermal injury (burn) pigmentation on the skin over the vein area and bleeding.

I understand that there are also some common side-effects including bruising, pain, or a tightening sensation in the thigh, leg, and ankle swelling, palpable lumps or hematomas (bleeding) that may need aspiration to relieve.

I also understand that despite the high clinical efficacy of the ELVT procedure, my physician cannot make any guarantees about my results or cure of my venous disorder.

Consent: These issues have been reviewed with me, and I have read and fully understand this consent form. I also understand that I have been directed not to sign this form unless all of my questions have been answered and explained to my satisfaction. By signing, I acknowledge that I have no further questions and consent to proceed with the EVLT procedure.

_________________________________________   ______________________________________
Patient Name     Witness

_________________________________________   ______________________________________
Patient or Guardian Signature    Date