PRIMARY VASCULAR CARE

PRIMARY VASCULAR CARE
T: 888-885-8346 | F: 862-295-1168
www.primaryvascularcare.com

Patient: ______________________ **DOB:** ______________________

Procedure(s): ______________________

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1. I hereby request and authorize Primary Vascular Physicians, ______________________
(my "Operating Physician") or his/her designees, and/or any assistants that may be selected and supervised by him/her (collectively, the "Primary Vascular Care") to perform upon me the Procedure.

2.The Procedure has been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the Procedure. I have also been provided with information regarding

(a) the nature and purpose of the Procedure and related care, treatment, services, medications, and interventions;

(b) alternatives to the Procedure as well as the relevant risks and benefits of such alternative procedure(s)

(c) clinical outcome if I do not elect to have the Procedure;

(d) the potential benefits and possible risks, side effects and complications associated with the Procedure including potential problems that might occur during recuperation; and

(e) the likelihood of achieving care, treatment and service goals.

(f) In addition, I acknowledge that reading materials were made available to me digitally (www.primaryvascularcare.com) and/or in print as a supplement to the discussion with my Operating Physician. The supplement includes a description of the procedure expectation, risks, and potential complications.

3.I understand that the Primary Vascular Care's Privacy Notice describes any limitations on the confidentiality of my information, and my Operating Physician has informed me of any special reporting obligations of which he or she is aware.

4. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of the proposed Procedure(s) and anesthesia, and the potential hazard of radiation to women of childbearing age, if applicable.

5. I have had sufficient opportunity to discuss my (the patient's) condition and treatment with the Operating Physician and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge and understanding upon which to base an informed consent to the proposed Procedure(s).

6. I consent to the performance of additional operations and procedures different from those now contemplated and deemed necessary or advisable during the course of the authorized Procedure(s) or anesthesia.

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7. I understand that after the Procedure, I may need to receive additional procedures as indicated on my treatment plan and that such treatment plan may require several sessions. For example, Superficial Venous Treatment may plan for one session a week for up to 4 to 6 weeks.

8. I consent to the retention or disposal of any tissues or parts which may be removed during the procedure(s).

9. I consent to the photographing, videotaping, or televising of the Procedure for the advancement of medical knowledge and /or education, with the understanding that my/the patient's identity will not be disclosed outside of the Primary Vascular Care.

10. I consent to the administration of sedative medications and exposure to the medical use of radiation by or under direction of the physician named above or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation and radiation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excrement. I understand that recall of the procedure is possible.

All types of anesthesia carry some risk of severe complications. Although rare, these include infection, drug reactions, blood clots, paralysis, stroke, heart attack, brain damage, and death. Anesthesia and radiation could injure a fetus if you are pregnant. Sometimes the type of anesthesia may be changed during surgery to better care for you or aid the surgeon's task. My clinician has fully explained to me the risks (both during administration of anesthesia and during the recuperation period), benefits and possible alternatives to administration of anesthesia, including not undergoing the procedure. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the administration of anesthesia.

11. I consent for the temporary suspension of any advanced directives and understand all resuscitation efforts will be made, should any unforeseen condition arise, during the course of the procedure and the immediate time under monitored care in recovery.

I, _ , had an informative discussion with the consenting party regarding each line item above.
All questions were answered fully and satisfactorily and the treatment plan and intervention was agreed upon. Reading materials were suggested for review and made available digitally at www.primaryvascularcare.com, or by fax, as a supplement to our discussion. The supplement includes a description of the treatment plan, procedure expectations, risks, and potential complications.

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INFORMED CONSENT

I confirm that i have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I agree that all of my questions have been answered fully and satisfactorily.

☐ HCP/Family consent obtained and noted above.

Patient*/Agent/Guardian/Surrogate:

Name: ________________________ Relationship, if signed by other: ________________

Signature: **X** ________________________ Date / Time: ________________

Signature of Interpreter (if used): ________________________

Print Name: ________________________

or Interpretation Line #: ________________________

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OPERATING PHYSICIAN'S and ASSISTANT CLINICIAN'S CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, risks, and alternatives to the above named procedure(s) / operation(s). (When applicable) I have provided counsel regarding the possible use of blood and / or blood products, its benefits attendant risks and alternative options including autologous blood, directed donor and intraoperative blood salvage. I believe that the patient or his / her representative understands what I have explained and answered. I have reviewed the information about the Procedure prior to the induction of anesthesia, and hereby confirm that the Procedure(s) is accurately described above

______________________ ______________________
Assisting Clinician's Signature **Date / Time**

______________________ ______________________
Operating Physician's Signature **Date / Time**