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

Patient: _____ **DOB:** _____

INFORMED CONSENT

Procedure(s) and Treatment Plan:
Superficial Venous ablation therapy of the lower extremities. Treatment plan includes one or more treatment sessions of **Endovenous Thermal (EVLT), Radiofrequency ablation(RFA), cyanoacrylate bioadhesive (VenaSeal), polidocanol injectable foam (Varithena), Compression Sclerotherapy ablation of the insufĀcient varicose and/or saphenous veins of the lower extremities.**

1. I hereby request and authorize Primary Vascular Care _____ (my "Operating Physician") or his/her designees, and/or any assistants that may be selected and supervised by him/her (collectively, the "PVC") 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. The risk and benefit of having the procedure performed in an out-patient facility versus a hospital have been explained to me. 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 PVC'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, if applicable.

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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 because of unforeseen conditions. The authority under this paragraph shall extend to treating all conditions that require treatment but were not known to the Operating Physician or anesthesiologist, or either of their designees and /or associates at the time the Procedure commenced.

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 PVC.

10. Risks: I have also been advised of the risks of this procedure which may include, but are not limited to:
    a. failure to access/close the vein or the vein later reopening
    b. inflammation of the treated vein with resulting pain, tenderness and redness (phlebitis
    c. skin bruising / discoloration / darkened pigmentation along the length of the treated vein
    d. deep vein thrombosis and/or pulmonary embolism (clot in a deep vein and/or lungs)
    e. nerve injury, temporary or permanent
    f. bleeding / infection / scar formation at the puncture site
    g. allergic reaction to anesthetics

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.

12. I acknowledge receipt of the Patient Bill of Rights.

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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.

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 below.

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**