

Informed Consent for Sclerotherapy

Customer's name: _____ Date: _____

The purpose of this procedure is to diminish unsightly spider veins. The procedure may require more than one treatment and may produce permanent vein removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments.

The following complications may occur with the Sclerotherapy vein removal system:

- 1. Risks: I understand there is a risk of bruising, burning sensation/pain, blood clots, allergic reaction, hyperpigmentation and temporary cramping.** These side effects usually take 1-4 weeks to heal, however pigmentation irregularities can take up to six months to heal.
- 2. Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
- 3. Effectiveness:** While new veins may appear over time, I understand removal can be permanent.
- 4. Treatments:** I understand removal of veins will take several treatments.
- 5. Allergic Reactions:** In rare cases, there may be an allergic reaction to the sclerosing solution.
- 6. There is a risk of scarring.**
- 7. I will follow all aftercare instructions as it is crucial I do so for healing.**

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____ (individual) and _____ (facility) and _____ (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____ Date _____

Sclerotherapy Technician Signature _____ Date _____