Trillium Vascular
ASSOCIATES

PATIENT INFORMED CONSENT- Endovenous Radiofrequency Treatment

I _____ (Patient or Guardian) authorize Dr._____

Associates and assistants to perform the following procedure: Endovenous Radiofrequency closure of my right and/or left greater saphenous vein.

I understand this means that the doctor, watching with ultrasound will thread a radiofrequency catheter and introducer sheath into the damaged vein from the knee towards the groin. When the introducer sheath and catheter are in position, he/she will turn on the energy source and slowly draw the introducer sheath and catheter down the inside of the vein, closing the vein with heat.

I understand the reason for this for this procedure is to correct my venous insufficiency caused by reflux or the backward flow of venous blood down my leg.

Alternatives include: Vein stripping, endovenous laser ablation, ultrasound guided foam sclerotherapy and continued use of medical graduated compression support hose.

This authorization is given with the understanding that any procedure involves some risks and hazards.

Some of the risks of this procedure are nerve injury (skin numbness or tingling), clot in the deep vein, skin thermal injury (burn), infection, allergic reactions and pigmentation over the area of the vein.

I understand that the more common risks are bruising, pain, leg or ankle swelling, lumps or hematomas.

Results are not guaranteed. I understand that no guarantee has been made to cure my vein disease or the results of the procedure.

I give permission for physicians learning to perform endovenous ablation to observe my procedure.

Patient consent: I have read and fully understand this consent form and understand that I should not sign this form unless all my questions have been answered and explained to my satisfaction. I have no further questions.

Witness **Patient/Guardian**

Date **Date**