

## Microphlebectomy Consent Form

Patient Name:

Date of Birth: \_\_\_\_\_

Guardian Name (if applicable):

Patient ID: \_\_\_\_\_

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

### **1** MY PROCEDURE

I hereby give my consent for Dr. \_\_\_\_\_ or associates, to perform **Microphlebectomy** upon me to treat varicose veins on the Left Right Bilateral lower extremities. I understand the procedure is to be performed at the First Hill Surgery Center.

I understand that the procedure or treatment can be described as follows:

**A small incision will be made directly over the veins so that the veins can be removed.**

This procedure may require anesthesia which will be administered by your physician. Your physician will be available to discuss this further with you on the day of your surgery.

### **2** MY BENEFITS

**Some potential benefits of this procedure include:**

- elimination of unsightly or painful veins, decreased vein related symptoms, decrease risk of bleeding from veins

### **3** MY RISKS

*I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

**These could include but may not be limited to the following:**

- bleeding, nerve injury, infection and recurrence

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

### **4** TISSUE DISPOSAL/PATHOLOGY

*Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.*

**5 MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to: compression stockings, powered phlebectomy and sclerotherapy. These alternative forms of treatment have their own potential risks, benefits and possible complications.

**I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.**

I understand the potential risks, complications and side effects involved with the proposed **Microphlebectomy** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Patient is unable to consent because \_\_\_\_\_. I therefore consent for the patient.  
 Authorized Consenter's Signature: \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
 Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mark this box if telephone consent

Witness Name: \_\_\_\_\_  
PRINT NAME

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: \_\_\_\_\_  
PRINT NAME

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_