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TRUE HEALTH

Consent for Sclerotherapy

This consent form is designed to provide the information you need to make an informed decision on whether to have sclerotherapy. If you do not understand the potential risks, please don't hesitate to ask us. I have requested that National Laser Institute and/or their staff and students treat me with sclerotherapy to treat superficial telangiectasias in my legs.

WHAT IS SCLEROTHERAPY?
Sclerotherapy is a popular method for eliminating superficial telangiectasias (spider veins} in which a solution (sclerosing agent} is injected into the veins.

DOES SCLEROTHERAPY WORK FOR EVERYONE?
The majority of people who have sclerotherapy will have significant improvement. Unfortunately, it is not guaranteed to be effective in every case. Approximately 10% of veins treated do not disappear after six treatments. In very rare cases, the condition may worsen after sclerotherapy treatment.

HOW MANY TREATMENTS WILLI NEED?
The number of treatments necessary to clear or improve the condition differs with each patient and depends on the extent of the spider veins. One to six or more treatments may be needed, but the average is three or four.

WHAT ARE THE MOST COMMON SIDE EFFECTS ASSOCIATED WITH SCLEROTHERAPY?
Itching. Depending on the solution used, you may experience some mild itching along the vein route. This itching normally lasts for 1to 2 hours, but may persist for 1to 2 days.

Transient Hyperpigmentation: Approximately 10% of patients who undergo sclerotherapy notice a discoloration (light brown streaks} after treatment. In almost every case, the veins become darker immediately after the procedure. In rare instances this darkening may persist for 4 to 12 months.

Sloughing: Sloughing is a small ulceration at the injection site that heals slowly over 1to 2 months. This occurs in less than 1% of patients who undergo sclerotherapy. A blister may form, open and become ulcerated. Any scars that follow should return to normal color. This usually represents injection into or near a small artery and is not preventable.

Allergic Reactions: Very rarely a patient may have an allergic reaction to the sclerosing agent used. The risk of an allergic reaction is greater in patients with a history of allergies.

Telangiectatic Matting: This is the development of tiny new blood vessels in the treated area. This temporary phenomenon occurs 2 to 4 weeks after treatment and usually resolves within 4 to 6 months. It occurs in up to 18% of women taking estrogen and in 2% to 4% of all patients.

Ankle Swelling: Ankle swelling may occur after treatment of blood vessels in the foot or ankle. It usually resolves om a few days and is lessened by wearing the prescribed support stockings.

Phlebitis: This Is a very rare complication seen in approximately 1out of every 1,000 patients treated for varicose veins greater than 3 to 4 mm in diameter. The possible dangers of phlebitis include a pulmonary embolus (blood clot}, which travels to the lungs, and postphlebitis syndrome, which can result in permanent swelling of the legs.

To reduce the risk of the complication, we strongly recommend that you wear graduated compression hose (15-20 mm Hg) for the first 24 hours after sclerotherapy and daily for a total of 3 days.

WHAT ARE THE ALTERNATIVES TO SCLEROTHERAPY?
Alternatives to treatment with sclerotherapy include laser treatment or no treatment at all.

WHAT IF YOU EXPERIENCE A PROBLEM AFTER SCLEROTHERAPY?
If you notice any type of adverse reaction, please call the office immediately.

I understand a qualified professional described the treatment risk and benefits and the decision to proceed was made by me without reservation. Available alternative procedures were discussed and recommendations were given based on my individual concerns.

We have a NO REFUND policy as all procedures performed in this office are elective, cosmetic procedures. No guarantees or promises are made to patients, as individual results may vary.

Comments:
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I acknowledge that I have been given the opportunity to ask questions and that my questions have been answered to my satisfaction. I have been adequately informed of the risks, benefits, and alternative methods of treatment.

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Patient Signature Date

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Patient Name (printed) Date

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Witness Date

PHOTO CONSENT FORM

I, ______________________________ grant permission to True Health for the use of the photograph(s) or electronic media images in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying True Health in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

Name ____

Address ____

City ____ State ________________ Zip _________

Phone ______________________________ Email _____________________________________

Signature ____ Date _____________________