Houston Heart Health
Dedicated to excellence in cardiovascular care

Advanced Vein & Vascular Center

INFORMED CONSENT FOR RF ABLATION PROCEDURE

PATIENT: _____ DOB: _____

PHYSICIAN NAME: ANIL KUMAR, M.D.

DATE OF PROCEDURE: _____

SIDE: ☐ Left Leg ☐ Right Leg VESSEL: ☐ GSV ☐ SSV ☐ ASV

Procedure Details: Endovenous Radiofrequency Ablation is a minimally invasive proven method used to eliminate the leakage (backwards flow of blood) in the saphenous vein. This leakage is usually the main cause of the visible bulging varicose veins and is often responsible for most of the symptoms associated with varicose veins. This method utilizes energy directed through a patented radiofrequency catheter inside the diseased vein causing the vein to close and become gradually absorbed by the body's natural healing response. The catheter is usually inserted at the level of the knee or calf but will vary depending upon your particular anatomy. The vein will then be anesthetized with a solution of normal saline and a local anesthetic, Lidocaine. The catheter is slowly removed while delivering radiofrequency energy to the vein wall causing it to heat, collapse and seal shut. This will relieve the back flow pressure, which is causing your leg symptoms and varicose veins. Following the procedure, we will put an ace-wrap on your leg which you will wear until the next morning. We will evaluate your results using ultrasound a few days to one week later.

Endovenous radiofrequency closure of the saphenous vein(s) treats the underlying cause of your symptoms and visible veins, but will not remove or eliminate the visible surface veins. The latter require treatment by other techniques such as phlebotomy and/or sclerotherapy.

Potential Risks and Side Effects: Following possible risks and side effects that are specific to Radiofrequency Vein Closure, have been explained to me in a language I understand: Failure to close the vein (or reopening), Bruising, Phlebitis (pain, tenderness, redness of the treated vein), Paresthesia (i.e., tingling, numbness and burning), Superficial thrombophlebitis (i.e., inflammation of a superficial vein caused by blood clot), Skin burn, permanent/temporary skin discoloration, very rarely AV Fistula (i.e., an abnormal connection between an artery and a vein), bleeding from the access site, Deep Venous thrombosis (i.e., blood clot in the deep vein), Edema (i.e., swelling) in the treated leg, Embolization (i.e., blockage of a vein or artery), including Pulmonary Embolism (i.e., blockage of an artery in the lungs), Hematoma (i.e., collection of blood outside the vessel), Infection or ulceration at the Access Site, Cellulitis, Visible Scarring.

I further understand that it is imperative for me to follow up with the treating doctor for any signs or symptoms of complications for they are better managed if addressed early.

Alternative Treatments: Because varicose veins and spider veins are not life-threatening conditions, Endovenous thermal treatment is not mandatory. Some patients get adequate relief of symptoms from wearing graduated support stockings/wraps. Surgical stripping, Endovenous chemical ablations (Sclerotherapy, Venaseal) may also be used to treat large varicose veins. The other option is to receive no treatment at all.

AUTHORIZATION

1. **Operation/Procedure**: I authorize the performance of the above Operation/Procedure by or under the direction of the Physician, and his/her assistant surgeon/associate or other individuals as necessary. I understand and agree that under the supervision of my Physician, allied health professionals (MA, RN, Technicians), Other physicians, residents/fellows, may

participate in my care. Physician has explained to me the nature and purpose of the Operation/Procedure, the alternative treatment to the Operation/Procedure, and the possible complications.

2. **Additional Operation/Procedures**: I also authorize the performance of additional operation/procedures that the above-named Physician may deem necessary to adequately treat the above probable diagnosis.

3. **Operation/Procedure Complications**: I understand that, there is no operation/ procedure in which complications have not been reported. Most complications are of a minor nature and respond to treatment. Serious complications can occur in any operation/procedure including death of the patient, excessive bleeding, nerve and blood vessel injury, infection, allergic reaction, complications due to anesthetics, heart attack or stroke.

4. **Results Not Guaranteed**: I understand that no guarantee or assurance has been made as to the results of the Operation/ Procedure and that it may not cure the condition.

5. **Follow up Care:** Varicose Veins and Spider Veins are chronic and recurrent conditions. I am informed that, the variety of treatments available will not offer a cure, but rather control the condition. I am aware that new veins may form in future and may require further treatments. Veins once treated are not available as a conduit for future bypass surgery.
I understand and agree that the recommend continuation of conservative therapy (Avoidance of immobilization, Periodic Leg elevation, Feet exercises, Compression therapy) and a regular follow up to monitor progress is a must for long term optimal venous health.

6. **Photography/Videotape**: I consent to photographing/ videotaping of operations or procedures showing portions of my body for medical, scientific or educational, promotional advertisements purposes providing that my identity is not revealed. I acknowledge that I will not receive any compensation for this. I hereby release Houston Heart Health Team/Agents from any claims which arise out of such use.

6. **Allergy/Anaphylaxis Education**: I have received education about anaphylaxis reaction that can rarely happen after Vein Ablation/Sclerotherapy.

7. **Residual Symptoms**: I further attest that I currently have leg symptoms despite use of conservative therapy.

☐ I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATION

PATIENT OR PERSON WITH AUTORITY TO CONSENT/DECLINE FOR THE PATEINT SIGNATURE	DATE	TIME
WITNESS SIGNATIURE		

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and answered all the patient's questions, and to the best of my knowledge, the patient has been adequately informed. The patient has consented.

PHYSICAN SIGNATURE