



## Consent Form for Leg Vein Treatment

The procedure to be performed is the Elite laser treatment for leg veins. I understand that the results from the treatment vary with each individual. The purpose of this treatment is to attempt to remove, fade, or significantly lighten the veins. This treatment is not a cure for vein disease, nor will it prevent further veins from developing. Multiple treatments may be necessary. Other methods available to treat these vessels include electrocautery, surgery, injection of sclerosing agents, and other laser or filtered light modalities.

The laser produces an intense burst of light that is absorbed by the targeted abnormal blood vessel without causing damage to the surrounding tissue. All personnel in the treatment room including myself will wear protective eyewear to prevent eye damage from the intense laser Light.

The sensation of the light is uncomfortable and may feel like a moderate to severe hot pinprick or burst of heat that lasts for only a few seconds. The area may appear reddish-purple in discoloration. Following treatment, the area should be treated delicately.

Photographs may be taken throughout the course of the treatment so my physician and I may assess the progress of laser therapy. These photographs may be used for educational purposes. If I do not want my photographs published, I will put it in writing that the photographs are not to be used under those circumstances.

I have been informed that blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin) are possible risks and complications of this procedure. I understand that sun exposure and not adhering to post care instructions may increase my chance of complications.

This consent is a written confirmation of a discussion I have had with my physician and/or nurse regarding the procedure aforementioned. I certify that I have read and understood all information presented to me before signing this consent form. I have also been given the opportunity to ask questions. Therefore, I authorize Dr. Foad to perform laser leg vein Therapy.

Patient \_\_\_\_\_ Date \_\_\_\_\_

(or legal guardian)

Witness \_\_\_\_\_ Date \_\_\_\_\_

