PATIENT CONSENT FORM
TREATMENT OF VENOUS INSUFFICIENCY OF THE LEGS

PATIENT NAME ______________________________________ DATE_________

I understand that I as a patient, have the right to be informed about my condition and the recommended surgical and treatment procedures to be used. This will allow me to make the decision whether or not to undergo the procedure after knowing the risks and alternatives involved. I recognize this disclosure is not meant to frighten or alarm me. It simply is an effort to make me better informed and I may give or withhold my consent to the procedure.

1. Dr. _________ has recommended the following procedures: Endovenous radio-frequency or laser ablation of the saphenous vein, with possible injection sclerotherapy of additional abnormal veins, micro-phlebectomy of large varicose veins, and ligation of a large saphenous vein. Any one or all of the above procedures may be performed as considered necessary to provide the recommended treatment. Treatment today is for my ________________ leg.
   The surgery is to be performed by Dr. _________ and his designated assistants. Local tumescent anesthesia and moderate conscious sedation may be administered to assure my comfort, and I understand fully the risks of the anesthetic.

2. Just as there are risks and hazards in continuing my present condition without treatment, I understand there are also hazards related to the performance of the procedures above. Some of these risks include failure to close and eliminate the saphenous vein, leg swelling, bruising, mild phlebitis (pain, tenderness, redness) of the treated vein, numbness and tingling in the treated area, and possible skin burns. Although rare in occurrence, blood clots may form in the deep veins and flow to the lungs, causing pulmonary emboli. Sclerotherapy treatment and micro-phlebectomy may result in pigment stains on the skin which will last for several months and up to a year or longer. On some occasions, the skin may break down into small ulcers after treatment.

3. I acknowledge that no guarantees have been made concerning these procedures. I have been advised that I may have additional detailed explanations of the procedures if I desire, including the diagnosis, treatment recommendations, alternatives, and risks. However, I am satisfied with the explanation given to me and my understanding of the surgery and treatment planned, and authorize Dr. __________and assistants to perform the recommended procedures outlined above.

4. I have had no solid foods for the past six (6) hours, and no liquids for the past three (3) hours except as instructed. I have followed instructions to discontinue certain medications if necessary. I understand that I can not have the surgery or treatments if I am pregnant.

The above information has been explained to the patient or the patient's representative.

______________________________ ______________
, MD Date

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Signature Date

ADVANCE COSMETIC CENTER
Dr. Tim Roham

PATIENT INFORMATION AND CONSENT FOR LASER/VEIN TREATMENT

This consent form includes general descriptions of various dermatological laser treatments. Including possible benefits and risks that may occur as a result of these treatments. Your doctor or nurse will describe and discuss the specific details of your procedure with you and answer your questions.

Please read this consent form carefully. This form may contain words that are unfamiliar to you. Please ask your doctor or one of his staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making a decision.

PROCEDURE

Treatment for Vascular Lesions (Unsightly Leg Veins)

Unsightly veins that result from heredity, pregnancy, trauma and the normal aging process are not necessary to the circulatory system and can be removed without creating a health problem.

The laser system is designed to treat veins safely and effectively. The laser light penetrates the vessels and generates heat, resulting in blood coagulation and vessel wall damage. This leads to the collapse of the blood vessels. There is a limit to the size of vessel that can be effectively treated. Benefits of this treatment include the possible reduction or elimination of superficial and /or deep veins.

A topical application of anesthetic may be applied before treatment to reduce discomfort during the procedure. Photographs of the treatment area may be taken for medical chart and future comparison. Multiple treatments may be necessary to achieve complete satisfaction. Short-term redness can be expected.

GENERAL RISKS

Eye injury due to use of the laser is a risk to the patient and to the clinician; however, the risks are almost completely eliminated with the use of proper eyewear. Due to the fact that medicine in an inexact science no guarantees can be made and more than one treatment may be necessary to achieve optimal results.

1) **Infection, with increased pain, burns, blistering, pigmentary changes (lightening or darkening), scarring, cold sores, and potential worsening of veins.**

While these risks are not common they do occur and each patient must make their own decision prior to treatment.

CONSENT FOR MEICAL/LASER TREATMENT

My signature below constitutes my acknowledgment that I,

____

Please print name

Am a competent, consenting adult of at least 18 years of age (or my parents or legal guardian is giving consent on my behalf), and further that I:

1) Have read and understand the information provided in this form.
2) Have had my procedure adequately explained to me by my clinician.
3) Have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.
4) Have received all of the information I desire concerning my procedure.
5) Consent to photographs of the treatment area.
6) Understand all post treatment recommendations and agree to adhere to them.
7) Freely assume any risks of complications or injury from known or unknown causes associated with or relating to, or otherwise arising out of this procedure.
8) Have the right to consent to or refuse any proposed procedure at any time prior to its performance.
9) Must notify the clinician if my medical history changes prior to subsequent treatments.
10) I consent to and authorize Dr. Tim Roham to perform the laser treatments of my veins.

______________________________________ ____________

Signature of Patient, or if under 18 signature of parent/guardian Date

______________________________________ ____________

Witness Date

ADVANCE COSMETIC AND LASER CENTER
Dr. Tim Roham
629 Camino De Los Mares
Suite 103, San Clemente Ca.92673
(949) 248-1900, fax (949) 248-1956

CONSENT FOR AMBULATORY PHLEBECTORMY

Patient Name____________________________________Date__________

___A) **Authorization for Vein Surgery**-I hereby authorize Dr. Tim Roham to extract or interrupt diseased veins for the purpose of attempting to improve the symptomatology and/or appearance of my legs/ arms.

____B) **Alternatives**- I understand the alternative treatments for varicose veins exist, including conservative treatments (elastic stockings), sclerotherapy (injection of sclerosing agents into diseased veins), stripping and vein litigation.

____C) **Risks**- The nature of the procedure to be performed has been explained to me, and I understand that among the known risks are bruising, swelling of the leg, temporary pigmentation, scarring, keloid formation, dermatitis, and secondary telangiectasias (spider veins). I am aware that in addition to the minor risks specifically described above, there are other risks that may accompany any surgical procedure, such as loss of blood, infection, inflammation in the venous systems with formation of a thrombus (clot), postoperative bleeding, and nerve trauma that may lead to temporary numbness.

___D) **Anesthesia**- I consent to the administration, to be administered by Dr. Tim Roham
I am aware that risks are involved with the administration of local anesthesia, such as allergic and toxic reactions to the anesthetic and cardiac arrest.

___E) **Proposed Treatment Results**- I know that the practice of medicine and surgery is not all exact science, and therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone as to the results that may be obtained. I have had sufficient opportunity to discuss my condition and proposed treatment with the doctor and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent to the proposed treatment. I hereby authorize the doctor to perform any other treatment that may be deemed necessary should he/she encounter an unhealthy or unforeseen condition during the curse of the procedure. A portion of the vein that is removed will be sent to a lab or pathology (you may receive a statement from the lab for the pathology).

___F) **Cooperation-** I agree to keep the doctor and staff informed of any changes in my permanent address, and I agree to cooperate with them in my after-care.

___G) **Photographs**- I consent to be photographed before, during, and after the treatment. I understand that these photographs shall remain the property of Dermatology Associates and may be published in scientific journals and /or shown for scientific reasons.

___H) **Informed Consent**- I certify that I have read and understand the above consent for surgery permit. It has been explained to me and I fully understand the inherent potential risks, complications, and results of both the surgical procedure and the anesthetic to be administered. I accept all responsibility for these or any other complications that may arise or result during the surgical procedure (s) to be performed at my request according to this consent and surgical permit.

Please initial each paragraph and sign below.

Patient__________________________________Witness______________________________