

Patient Consent Form

I hereby authorize Dr. _____ to treat my saphenous vein(s) using an endovenous radiofrequency ablation technique, also known as the VNUS Closure® procedure. He has explained that the device used to perform this procedure is known as the VNUS Closure System; it is a commercially available product used specifically for this purpose.

Dr. _____ has explained that common symptoms of varicose veins, such as heaviness and pain after standing for a long time, arise from malfunctioning valves in the saphenous vein (the main superficial system vein in the thigh and calf). Satisfactory treatment of varicose vein symptoms is usually achieved by closing the saphenous vein. Although treatment of the saphenous vein using the VNUS Closure System should reduce the pressure in my varicose veins and thus relieve many of my symptoms, I understand this consent for the VNUS Closure procedure for treatment of my saphenous vein does not include actual removal of the varicose veins, which may still be visible after the procedure. I also understand that my insurance company may not approve reimbursement for the VNUS Closure procedure for treatment of the saphenous vein and will not reimburse Dr. _____ for the procedure of actually removing the cosmetically objectionable varicose veins.

The general nature of the VNUS Closure procedure for treatment of the saphenous vein has been explained to me. I understand that among the known risks of this procedure are failure to close the saphenous vein, leg swelling, bruising, mild phlebitis (pain, tenderness, redness) over the treated vein, numbness and tingling in the treated area, skin burns, vessel perforation and pulmonary embolisms that may need to be treated with additional surgery. I am aware that in addition to the risks specifically described above, there are other risks that may accompany any surgical procedure, such as intra- and post-operative blood loss, infection, and clot formation in the venous system which may require additional medication or surgical intervention, as determined by the physician.

Dr. _____ has not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. _____ and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent for treatment.

Patient Name

Witness



Premiere Surgical Specialists
General, Vascular, Trauma & Laparoscopic Surgery

Alvaro H. Devia, M.D., F.A.C.S.
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PREPARING FOR YOUR ENDOVENOUS LASER PROCEDURE (EVLT®)

Your EVLT laser ablation procedure is scheduled for:

DATE: _____ at _____ AM/PM.

Please arrive approximately 10 minutes prior to your appointment time to review any last paperwork. A friend or family member should come with you to drive you home after the procedure.

You may eat a light breakfast on the morning of your procedure. Wear loose-fitting shorts, or very loose pants that you can pull on over the leg bandage that will be placed on after the procedure.

Take a shower and wash your leg with antibacterial soap on the morning of your procedure. Please do not apply any lotions to your leg before your procedure. It may be necessary to shave some hair in your groin region to facilitate the ultrasound probe, prior to the procedure.

If you feel anxious and cannot relax prior to the procedure, you may take a sedative tablet one hour prior to the procedure. Please request this from your physician. DO NOT drive after you have taken the sedative.

You MUST bring your prescription Class II stockings with you on the day of the procedure. If you fail to bring them, we will have to cancel your appointment, and reschedule for another date. If you have questions or problems filling your prescription for the stockings, please contact our office for assistance.

If you have any questions or concerns prior to your appointment, please do not hesitate to call our office.

Patient Signature: _____ Nurse: _____



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Patient Informed Consent for the EVLT® Endovenous Laser
Ablation Procedure

I _____ authorize Dr. _____,
his associates and assistants, to perform the following procedure: Endovenous Laser Ablation of
my right/left (circle one or both) greater saphenous vein.

I understand this means that the physician, using ultrasound for guidance, will direct a catheter
and subsequently, a laser fiber, into the damaged vein from a point distal to the groin up towards
the groin area. I understand that once the laser fiber is positioned and anesthetic is injected
around the vein, that he will activate the laser and pull all of the components down the inside of
the vein, closing the vein with heat energy.

I understand that the reason for this procedure is to correct my venous insufficiency caused by the
reflux, or backward flow, of blood down my leg.

I understand there are alternatives to this procedure, and they have been explained to me. These
procedures include; Surgical Stripping and Ligation, radiofrequency ablation (VNUS®) and
Ultrasound Guided Sclerotherapy. Despite these alternatives, I consent to the EVLT® procedure
understanding that there are risks with any invasive procedure.

These risks have been thoroughly explained to me, and include but are not limited to; infection,
bleeding, scarring, allergic reaction to medications, nerve injury (paresthesia), clot in the deep
vein (DVT-Deep Venous Thrombosis), thermal injury (burn) pigmentation on the skin over the
vein area and bleeding.

I understand that there are also some common side-effects including bruising, pain or a tightening
sensation in the thigh, leg and ankle swelling, palpable lumps and or hematomas (bleeding) that
may need aspiration to relieve.

I also understand that despite the high clinical efficacy of the EVLT® procedure, my physician
cannot make any guarantees about my results or cure of my venous disorder

Consent: These issues have been reviewed with me, and I have read and fully understand this
consent form. I also understand that I have been directed not to sign this form unless all of my
questions have been answered and explained to my satisfaction. By signing, I acknowledge that I
have no further questions and consent to proceed with the EVLT® procedure.

Patient Signature

Date

Witness

Date



**Patient Informed Consent for the EVLT® for Development
and Display of Photograph**

I _____ (Patient) authorize Premiere Surgical Specialists to photograph and develop film of _____ (body part) for the purpose of authorization from my insurance company and/or tracking of progress post-operatively.

I understand this means that the above listed body part will be photographed, and that every effort will be taken to protect my privacy. I understand that my medical record number will be displayed in the photograph for identity purposes.

I understand that photographs taken both pre-operatively and post-operatively will be developed at Premiere Surgical Specialists.

I understand that photographs may be sent to and kept by my insurance company. I also understand that Premiere Surgical Specialists will keep a copy of the photographs in my chart.

I authorize Premiere Surgical Specialists to display pre-operative and post-operative photographs in an album for the purpose of other EVLT candidates to observe. These photographs will not have my name or date of surgery listed, nor will they be allowed outside of the premises.

Patient Signature

Date



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POST-EVLT PATIENT INSTRUCTIONS

1. Your leg was wrapped with a compression bandage prior to putting on your compression stockings. This is to remain on for 24 hours. Your follow-up appointment is scheduled for: DATE: _____ at _____ AM/PM. Should you have problems, discomfort or feel numbness in your foot or toes, please contact our office immediately. The compression bandage can be removed in 24 hours. At that time you should wear your compression stockings for another 3 weeks. The benefit of following these instructions will be a reduction in bruising, swelling and pain.
2. You will be expected to walk immediately after receiving these instructions for at least 20 minutes here at our office. It is advised that you keep active and walking for the remainder of the day. Not doing so could result in excessive bruising and inadequate healing. Normal activity can be resumed immediately, but strenuous exercise can cause the vein to reopen, so please avoid hot baths and vigorous activity such as gym workouts until at least 7 days following the procedure.
3. Recovery from EVLT is usually trouble-free. It is normal to feel a "tightening" sensation in your leg after a couple of days, and it may last for a few days. You may also notice "pinkish" fluid drainage on the day of your procedure. Your thigh may also be slightly tender to the touch for a few days. This discomfort can generally be managed with over-the-counter analgesics like Tylenol or Motrin, but please avoid aspirin-based products unless otherwise recommended or prescribed.
4. As with any invasive procedures, problems can develop. If you develop an acute fever (more than 100 F or 38.C), severe or worsening pain/swelling, or an excess of bright red blood soaking your bandages ("pinkish" fluid is normal) please call our office or the exchange immediately.

These post operative instructions were reviewed with me prior to discharge, and I understand the expectations of my attending physician. I understand I must call the office immediately if any unexpected side-effects arise.

Patient Signature: _____ Nurse: _____



CANCELLATION FEE

Due to the complexity of the EVLT procedure scheduling, we ask that you please allow a 72 business-hour notice for cancellation. Should you fail to do so, a \$100 cancellation fee may be assessed.

Patient Signature

Date