Informed consent for
SCLEROTHERAPY

Please read carefully before signing.

I have been fully informed concerning the sclerotherapy procedure. I understand the treatment to be for the purpose of elimination of spider veins.

I further understand that most medical procedures involve the element of risk. Side effects of this treatment may include: allergic reactions, superficial clot formation, temporary phlebitis, infection, bleeding, failure to eliminate veins, ulcer formation, pigment staining of the skin, and bruising, these effects have been fully explained to me.

I understand that the average patient requires 3-5 treatments to each spider vein in order to achieve results, and that I may not fall into this range, possibly needing more or less treatments.

I hereby acknowledge that this information has been given to me, and that all of my questions have been satisfactorily answered. I authorize the Mountcastle Plastic Surgery and Vein Institute, physician or staff, to perform the above-described procedure(s).

Patient: ____ Date:________________

Doctor: ____ Date:________________

Witness: ____ Date:________________