



**Informed consent for
PHLEBECTOMY**

Please read carefully before signing.

I have been fully informed concerning the Ligation/Phlebectomy procedure. I understand the treatment to be for the purpose of elimination of varicose 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, scars/keloid type scars, failure to eliminate veins, ulcer formation, pigment staining of the skin, and bruising. These effects have been fully explained to me.

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: _____