dM cosmetic & wellness centre

Initial HERE

CONSENT TO SCLEROTHERAPY OF VARICOSE AND SPIDER VEINS

NATURE AND PURPOSE OF SCLEROTHERAPY

I authorize Ihab Matta, M.D, medical director of DM Cosmetic & Wellness Centre, to inject a sclerosing solution into my affected veins for the purpose of attempting to improve the symptoms and appearance of my legs.

ALTERNATIVES

I understand that alternative treatments for varicose veins do exist. These alternative treatments include observation, conservative therapy (with support compression hosiery) and surgery.

RISKS

The nature of the procedurehas been explained to me, and I understand that among the known risks are bruising, pain and other discomfort, swelling of the leg, pigmentation (skin discoloration), skin necrosis (with wounding and scarring), secondary telangiectasias (spider veins), and allergic reaction.

I am aware that , in addition to the risks specifically described above, there are other, extremely rare risks such as infection, inflammation of the deep venous system, with formation of a thrombus (clot) and pulmonary embolism; intra arterial injection, with loss of a limb; and nerve compression that may lead to numbness. The risks described in the above paragraphs can be either temporary or permanent.

I hereby authorize Dr. Matta, to perform any other treatment that may deem necessary should an unforeseen condition be encountered.

PROPOSED TREATMENT

I understand that injections may be required and performed at sites away from visible veins for the purpose of treating the origin of the problem. I also understand that the sclerosing solution, it's dosage, and the number of injections will be determined according to my particular condition.

I know that the practice of medicine and surgery is not an exact science, and therefore, results cannot be predicted. No guarantee or assurance has been given me by anyone as to the results that may be obtained.

I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. Matta, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base informed consent to the proposed treatment.

COOPERATION

I agree to keep Dr. Matta, M.D. and staff informed of any changes in my permanent address, and I agree to cooperate with them in my post treatment care.

PHOTOGRAPHS

I consent to be photographed before, during, and after the treatment. I agree that these photographs shall be the property of DM Cosmetic & Wellness Centre and/or Dr. Matta and that they may be published in scientific journals and/or shown for scientific reasons.

Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

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CONSENT TO SCLEROTHERAPY OF VARICOSE AND SPIDER VEINS--PAGE 2

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INFORMED CONSENT

_____ I certify that I have read the above consent form for Sclerotherapy. The form has been fully explained to me, and I completely understand it. I fully understand the inherent potential risks, complications, and results of the procedure, as made know to me by this consent form. I accept full responsibility for any complications that may arise during the procedure, which is to be performed at my request according to this consent form.

_____ I understand that any treatment provided may or may not meet my expectations. I understand and agree that there is no compensation or refund of monies paid in any event.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta