INTERVENTIONAL CARDIOLOGY MEDICAL GROUP, INC.
23101 SHERMAN PLACE. SUITE 110 • WEST HILLS, CA 91307
PHONE (818)702-8800 • FAX (818)702-0080

Endovenous Ablation Consent Form

I _____ (patient or guardian) authorize Interventional Cardiology Medical Group and its associates and assistants to perform the following operation or procedure: Endovenous Catheter Ablation of my leg superficial veins and all related necessary procedures that may arise therefrom.

I understand this means that the doctor, watching with ultrasound, will thread a small catheter into the damaged vein. When the catheter is in position, he/she will proceed to close the vein throughout its course using adhesive or heat.

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

Alternative treatments include: vein stripping, vein ligation, ultrasound guided injections, visual injections and graduated compression support hose.

RISKS: This authorization is given with the understanding that any procedure involves some risks and/or hazards. Some of the risks for this procedure are bruising, hematomas, skin numbness or tingling, pain in the treatment area, clot in the deep vein, leg swelling, pigmentation over the vein, thermal (burn) injury, or allergic reaction to the adhesive.

I also understand that risks for any procedure may include, infection, bleeding, nerve injury and other allergic reactions.

RESULTS ARE NOT GUARANTEED: I understand that no guarantee has been made as to the results of the procedure and that it may not cure the condition.

PATIENT CONSENT: I have read and fully understand this consent form. I understand that I should not sign this form unless all my questions have been answered and explained to my satisfaction. I have no further questions.

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date

_____ _____
Physician Signature Date