



Center for
Surgical Specialties
at WATERBURY HOSPITAL

**Patient Informed Consent for the EVLT® Endovenous Laser
Ablation Procedure**

I _____ (Patient or Guardian) authorize Dr. _____, his associates and assistants, to perform the following procedure: Endovenous Laser Ablation of my right/left (circle one or both) greater/lesser (circle one or both) 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 below 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 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 may be some mild 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 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. By signing, I acknowledge that I have no further questions and consent to proceed with the EVLT® procedure.

Patient Name

Witness

Patient or Guardian Signature

Date