

INFORMED CONSENT FOR LEG VEINS

I hereby authorize James D. Wethe, MD and/or designated associates and assistants to perform the laser reduction of leg veins or vascular lesions on my skin.

The nature and purpose of the procedure as well as the therapeutic alternatives have been explained to me. James D. Wethe, MD and/or designated associates and assistants has fully explained to me what will happen during the surgery and has answered all my questions. In addition, I understand the complications such as infection, bleeding, discoloration of the skin, a wound with blistering and oozing can occur and that a scar, although more than likely minimal can occur.

I am aware of the following possible experiences/risks with Laser Leg Vein Treatment:

- DISCOMFORT – Some discomfort may be experienced during laser treatment.
- WOUND HEALING - Laser treatment can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
- BRUISING/SWELLING/INFECTION – With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
- PIGMENTED CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
- SCARRING – Scarring is a rare occurrence, but it is a possibility when the skin’s surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

I acknowledge that the information I have received is sufficient for me to consent to and authorize the procedure described above. I have had the opportunity to ask questions concerning my condition, the procedure, alternatives and risks, and all questions have been answered to my satisfaction.

I also give James D. Wethe, MD and/or his designee(s) permission to take photographs of the areas being treated for the sole use of tracking the progress of my treatment. Any other use of photographs will require prior and supplementary consent.

Patient Printed Name

Patient’s Signature (or Parent/Guardian)

Witness

Date: _____