Lexington
Plastic Surgery

LASER VEIN TREATMENT

REQUEST FOR TREATMENT AND INFORMED CONSENT

PATIENT:_____ DATE: ____/____/_____
I understand that the above named procedure has been explained to me in general terms and is to be performed on me.
I understand that:

1. The DIAGNOSIS REQUIRING THIS PROCEDURE is telangiectasia(s) (spider veins), hemangioma(s), reticular veins, and/or vascular malformation(s).
2. The NATTURE OF THIS PROCEDURE is to use laser energy to clot off unwanted vessels or vascular lesions. These treatments generally require no anesthesia. MULTIPLE TREATMENTS MAY BE REQUIRED.
3. The PURPOSE OF THIS PROCEDURE is to minimize undesired veins or vascular lesions, in order to improve the appearance of the affected area.
4. PRACTICAL ALTERNATIVES TO THIS PROCEDURE include doing nothing and accepting the circumstances of my medical condition, or in certain instances, sclerotherapy, excisional surgery or chemical agents may be used.
5. RISKS FOR THIS PROCEDURE INCLUDE (but are not limited to): Skin discoloration; regrowth of veins; bruising; swelling; blistering; infection; pain; itching; scarring; incomplete removal of the veins; eye injury from laser light. Laser surgery may result in swelling, bruising, crusting or flaking of the treated area, which may require several weeks to heal. Once the surface was healed, it may be pink and sensitive to the sun for an additional several weeks. Bruising of the treated area is commonly seen for 4-8 weeks.
6. I understand that my expectations should be realistic and I should consider not undergoing the procedure if my expectations are greater than the reality of this treatment. Several treatments may be required to decrease the veins in a determined area. However, some patients may not experience vein clearance even after multiple laser procedures. Results depend on many factors and it may not be possible to make every vein disappear.
7. I consent to the taking of pictures during the course of my treatment for the purpose of helping to plan and assess the proposed therapy. No photographs will be shown to patients or physicians without my permission.
8. I voluntarily consent to allow Dr. Gerstle and all medical personnel under their supervision and control and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described by otherwise referred to herein.
9. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. MEDICAL TREATMENTS ARE NOT AN EXACT SCIENCE AND I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE CAN BE GIVEN TO ME CONCERNING THE RESULTS OF THE TREATMENT.

Signature of person giving consent: _____Date:_____

Witness:_____Date:_____