Lexington Plastic Surgery

THEODORE L. GERSTLE, M.D.
3363 Tates Creek Rd Suite 209
Lexington, Kentucky 40502
(859) 279-2111

SCLEROTHERAPY / CRYOTHERAPY

REQUEST FOR TREATMENT AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT: _____ DATE: ____/____/____ I

understand that the above named procedure has been explained and is to be performed on me.

The following has been explained to me in general terms and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is telangiectasias (spider veins), varicose veins, hemangioma or vascular malformation.

2. The **NATURE OF THE PROCEDURE** is to attempt to clot off unwanted veins so they will dissolve away. This is accomplished by injecting very small quantities of clotting medicine in the individual veins. Alternatively, a laser may be used to clot off the veins with a light beam. These treatments generally require no anesthesia. MULTIPLE TREATMENTS ARE ANTICIPATED WITH THIS CONDITION.

3. The **PURPOSE OF THIS PROCEDURE** is to eliminate undesirable veins in order improve the appearance of the affected area.

4. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include doing nothing and accepting the circumstances of my medical condition. If I choose not to have the above named procedure, my medical condition may get worse, better, or stay the same. However, failure to have the procedure may result in an increase in the number and/or severity of the veins with the possible need for more extensive treatment if the condition progresses and remains undiagnosed or untreated. Medications, exercise, sun exposure, pregnancy, aging and other factors may all contribute to future changes in my medical condition.

5. **RISKS FOR THIS PROCEDURE INCLUDE**(but are not limited to): Skin discoloration, Regrowth of veins, Bruising, Swelling, Skin ulceration, Infection, Allergic reaction to medication, Pain, Telangiectatic matting (concentration of a large number of very small veins), Itching, Thrombophlebitis and Scarring.

6. Even though the risks and complications cited above are infrequent, they are the ones peculiar to the procedure and are of greatest concern. Complications may also be increased due to my medical condition, personal. habits or failure to comply with physician's recommendations.

7. There may be a need for immediate or other additional surgery to treat the above complications, which could include hospitalization, time off work and additional expense to me.

Initials _____(Person signing)

8. I understand that my expectations should be realistic and I should consider not undergoing the surgery if my expectations are greater than the reality of this treatment. Psychological problems may occur due to unrealistic expectations of the surgery or difficulties in accepting changes in my appearance.

9. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

10. 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. If any portion of my surgery is to be billed to insurance (this does not include cosmetic procedures), I understand my insurance carrier may require photographs to process my claim.

11. Ivoluntarily consent to allow Dr. Gerstle and all medical personnel under his direct supervision and control and all other personnel who may otherwise be involved in performing such procedures to perform the procedure(s) described or otherwise referred to herein.

12. 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.

Signature of person giving consent:_____ Date: _____

Relationship to patient if not the patient:_____

Witness:_____ Date: _____

SUBSEQUENT TREATMENTS:

Consent reviewed	Date	Consent reviewed	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____