Preoperative Instructions for Ultrasound-guided Sclerotherapy

Patient Name: _____ DOB: _____

- Shave the operative leg from groin to ankle the night before your surgery.
- Shower before your visit, as you will not be permitted to shower after the procedure for 72 hours.
- Do not apply any type of moisturizer to your leg on the day of the procedure. Clean and dry skin.
- Wear comfortable two –piece outfit and be aware that your underwear may be stained by the sterile prep solution. Wear loose pants and shoes as a dressing may applied on operated leg after procedure. Ie: sweats, shorts, sleepers
- Please bring your thigh high compression stockings to every visit.
- We encourage patients to eat a small meal, and drink a small amount of fluid two hours before arriving to our office. **You will not have general anesthesia.**
- Please arrange for someone to drive you home following procedure.
- You may take Tylenol 500mg one tablet, one hour prior to arrival time for pain.

The following appointments are scheduled:

Procedure date and arrival time:_____.

Venous ultrasound date and arrival time:_____.

Follow up visit with Dr. Atiemo or Elisa Hilburn, NP on:_____.

Postoperative Sclerotherapy

There is no need to change your lifestyle after treatment. Patients can return to work immediately; there are no restrictions on any activities, in fact, sport activities and/or exercise routines can and should be continued.

- Walking is the best thing that you can do for your legs following the procedure and is essential to a timely and successful recovery.
- Within 20 minutes of your procedure, walk for 20 minutes.
- Walk 3 times a day for 20 minutes at a time.
- Anti-inflammatory medication containing ibuprofen may be taken as needed.
- If an absorbent pad is in place under your stockings, to avoid a rash do not leave the pad in place for more than 12 hours.
- Applying an ice pack for 15 minutes every 2 hours can give some relief if needed.
- If traveling, wear your stockings, get up frequently and walk around to assure healthy circulation in your legs.

FOLLOW UP with Dr. Atiemo/Elisa Hilburn, NP _____ @_____

Mountain Heart™

Endovenous Radiofrequency Treatment / Endovenous Laser Treatment / Ultrasound-guided Sclerotherapy / Microphlebectomy Consent Form

PATIENT NAME: _____ DOB: _____

PLEASE INITIAL THE FOLLOWING:

_____ 1. **I authorize** the performance of Endovenous Radiofrequency Ablation, Endovenous Laser Ablation, Ultrasound-guided Sclerotherapy, Cosmetic Sclerotherapy and Microphlebectomy as indicated to be performed on me.

Possible Side Effects- these typically are temporary but last any amount of time:

_____ 2. Superficial phlebitis (inflammation of the vein)
_____ 3. Hyperpigmentation (darkening of the overlying skin)
_____ 4. Paresthesia (numbness) this can last any amount of time, but usually lasts a few months.
_____ 5. Neovascularization (growth of new veins) that you may choose to have treated.
_____ 6. Vein nodularity; (lumps/bumps felt under the skin)

Possible Side Effects, although are rare, can include:

_____ 7. Adverse Allergic reactions to medication used for treatment.
_____ 8. DVT/PE (blood clot) that may require medical treatment.
_____ 9. Skin ulceration or burn.
_____ 10. Scars
_____ 11. Infection
_____ 12. Long term swelling/lympedema

_____13. Results of these procedures have been excellent, however, it is important to remember that each patient's result may vary; the symptoms of varicose veins almost always improve, but could potentially remain the same or worsen.

_____ 14. I have also been informed that it is necessary for me to return for all treatment visits as scheduled/needed to optimize results, and the Mountain Heart, PLLC requests I have re-check visits up to one year. I recognize that the practice of medicine and that of Ultrasound guided Sclerotherapy, Endovenous treatment, cosmetic sclerotherapy and microphlebectomy is not an exact science and acknowledge that no guarantees, expressed or implied have been made to me.

_____ 15. I hereby represent that the information that has been provided to me is sufficient for me to intelligently and rationally decided to give my consent for this and all subsequent treatments, including additional ultrasound scans, by Mountain Heart, PLLC for the same described treatment.

_____ 16. I gave permission for before and after photographs to be taken of the areas treated and said photographs could be used for promotional and/or educational purposes.

By signing my name below I certify that I have read, or have had read to me, the contents of this form. I understand This risks and alternatives involved in the procedure. I understand that I may ask and will receive answers to any questions I might have regarding this treatment on this visit or any subsequent visit to Mountain Heart, PLLC.

PATIENT SIGNATURE: _____ DATE: _____ WITNESS:_____

DOCTOR SIGNATURE: _____ DATE: _____