Mountcastle
Plastic Surgery & Vein Institute

Informed consent for VNUS Closure procedure™

I hereby authorize Dr. Mountcastle to treat my saphenous vein(s) and/or perforating veins using an endovenous radiofrequency ablation technique, also known as the VNUS Closure™ procedure. He has explained that the device used to perform this procedure is known as the VNUS Closure system; it is a commercially available product used specifically for this purpose

Dr. Mountcastle has explained that common symptoms of varicose veins, such as heaviness and pain after standing for a long time, arise from malfunctioning valves in the saphenous and/or perforating veins (the main superficial system vein in the thigh and calf) and/or perforating veins. Satisfactory treatment of varicose vein symptoms is usually achieved by closing the saphenous vein. Although treatment of the saphenous vein and/or perforating vein does not include actual removal of the varicose veins, which may still be visible after the procedure. I also understand that my insurance company may not approve reimbursement for the VNUS Closure procedure for treatment of the saphenous vein and/or perforating veins.

The general nature of the VNUS Closure procedure for treatment of saphenous veins and/or perforating veins has been explained to me. I understand that among the known risks of this procedure are failure to close the saphenous vein, leg swelling, bruising, mild phlebitis (pain, tenderness, redness) over the treated vein, numbness and tingling in the treated area, skin burns, vessel perforation and pulmonary embolisms that may need to be treated with additional surgery. I am aware that in addition to the risks specifically described above, there are other risks that may accompany any surgical procedure, such as intra- and post- operative blood loss, infection, and clot formation in the venous system which may require additional medication or surgical intervention, as determined by the physician.

Dr. Mountcastle has not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. Mountcastle and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent for treatment.

I understand that the VNUS closure procedure will not treat or decrease the appearance of spider veins and/or telengectasias. _____

I understand I should not have this procedure done during pregnancy . _____

I understand scarring, bruising, skin discoloration, telengectasias may occur. _____

_____ _____

Patient name Witness