Patient Informed Consent for Stab Phlebectomy

I,_____(Patient or Guardian) authorize Dr. Gopichand Kapu, his associates and assistants, to perform the following procedure: Stab Phlebectomy of my right /left varicose veins.

I understand this means that the physician will introduce small incisions above the veins to remove the vein segments. The physician will give local anesthetic (xylocaine 1%) at each incision site.

I understand that the reason for this procedure is to help correct my venous insufficiency.

I understand that there are alternative methods of treatment and they have been explained to me, e.g. vein stripping, compression hose 30-40 mmg to help alleviate symptoms.

The risks of this procedure include bleeding, infection, allergic reaction to medication, scarring, and pigmentation changes in the skin.

I understand there are also some common side-effects including bruising, tenderness over area, and/or discoloration from trapped blot that will fade with time.

These issues have been reviewed with me, and I have read and fully understand this consent form. I also understand that I have been directed not to sign this form unless all my questions have been answered and explained to my satisfaction. By signing I acknowledge that I have no further questions and consent to the stab Phlebectomy.

_____	_____
Patient Name	Witness
_____	_____
Patient or Guardian Signature	Date