Consent Form—Vascular Treatment

I request and authorize _____ or a designated, licensed healthcare professional to perform a procedure on me known as: _____ using the Elite MPX Laser.

I understand that the results from the treatment vary with each individual. The purpose of this treatment is to attempt to remove, fade, or significantly lighten the veins. This treatment is not a cure for vein disease, nor will it prevent further veins from developing. Multiple treatments may be necessary.

Other methods available to treat these vessels include: electrocautery, surgery, injection of sclerosing agents, and other laser or filtered light modalities.

The laser produces an intense burst of light that is absorbed by the targeted abnormal blood vessel without causing damage to the surrounding tissue. All personnel in the treatment room including myself will wear protective eyewear to prevent eye damage from the intense laser light. The sensation of the light is uncomfortable and may feel like a moderate to severe hot pinprick or burst of heat that lasts for only a few seconds. If the physician elects to use some form of anesthesia, then all options will be discussed with me.

Immediately following treatment, the area may appear flushed and warm, but there should be no bruising. The flushness should fade over the course of a few hours. The skin may have redness that lasts 2–3 days (similar to a scratch). Following treatment, the area should be treated delicately.

Photographs may be taken throughout the course of the treatment so my physician and I may assess the progress of the laser therapy. These photographs may be used for educational purposes. If I do not want my photographs published, I will put it in writing that the photographs are not to be used under those circumstances.

I have been informed that blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin) are possible risks and complications of this procedure. I understand that sun exposure and not adhering to post care instructions may increase my chance of complications. I will care for the skin area(s) gently cleaning daily with gentle, antibacterial cleanser and applying a broad spectrum (UVA/UVB) sun block SPF 30 or greater. The sun block should be applied before leaving the office.

This consent is a written confirmation of a discussion I have had with my physician and/or nurse regarding the procedure aforementioned. I certify that I have read and understood all information presented to me before signing this consent form. I have also been given the opportunity to ask questions.

I authorize the licensed health care professional listed here: _____ to perform laser vascular therapy.

Patient_____ Date_____
(or legal guardian)

Witness_____ Date_____