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## CONSENT – RADIO FREQUENCY ABLATION OF VEINS

I hereby authorize Dr. Blignaut to treat my veins using an endovenous radiofrequency ablation technique and/or sclerotherapy. It has been explained to me that the device used to perform this procedure is known as the VENEFIT procedure; it is a commercially available product used specifically for this purpose.

It has been explained to me that common symptoms of varicose veins, such as heaviness and pain after standing for a long time, arise from malfunctioning valves in the saphenous vein (the main superficial system vein in the thigh and calf). Satisfactory treatment of varicose vein symptoms is usually achieved by closing the saphenous vein. Although treatment of the saphenous vein using the VENEFIT procedure should reduce the pressure in my varicose veins and thus relieve many of my symptoms, I understand this consent for the VENEFIT procedure for treatment of my saphenous vein does not include actual removal of the varicose veins, which may still be visible after the procedure.

The general nature of the VENEFIT procedure for treatment of the saphenous vein 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 dvt that may need to be treated with additional medication and / or 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.

I understand that neither surgery results nor freedom from potential complications can be guaranteed. I have had sufficient opportunity to discuss my condition and proposed treatment with Dr Blignaut 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 have received printed post-operative instructions.

Regarding professional fees, I understand that Dr Blignaut charges above medical aid rates. I understand my medical scheme might not fully reimburse for this procedure. I remain responsible for payment of the full account within 30 days from today's date.

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**Patient Name**

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**Patient Signature**

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**Date**

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**Patient file number**

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