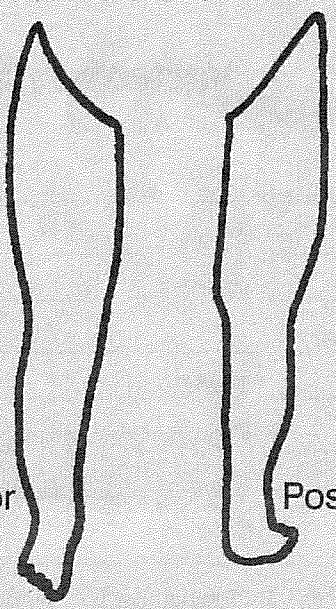
RECOMMENDATIONS

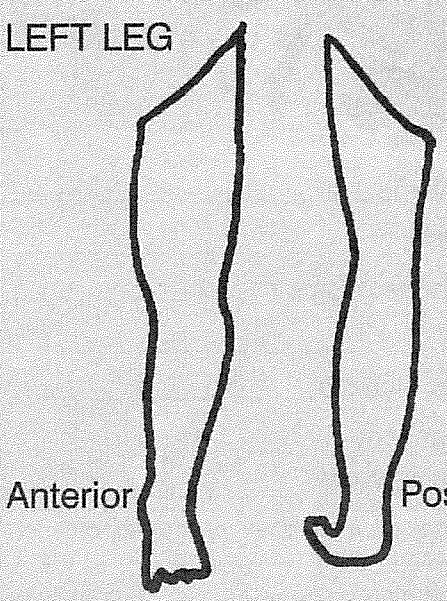
RIGHT LEG

- ☐ Sclerotherapy - Varicose _____
- ☐ Sclerotherapy - Spider / Retic_____
- ☐ Veinlite Treatments _____
- ☐ UGI
  - ☐ Left ☐ Right
- ☐ Compression Therapy
- ☐ Massage Therapy
- ☐ Exercise/elevation _____
- ☐ Referrals _____



Saphenofemoral _____
Varicose _____
Saphenopopliteal _____
Reticular _____
Telangietasias _____
Dorsalis Pedis _____ ☐ ADEQUATE
Corona _____
Hemosiderin _____
Edema _____
Ulcer _____

LEFT LEG



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Varicose _____
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CONSENT FORM

This form is designed to provide you with the information you need to make an informed decision on whether or not to have Sclerotherapy performed. If you have any questions or do not understand any potential medical risks please do not hesitate to ask before signing this form.

I authorize Dr. Deborah Martin, M.D., C.C.F.P., (E.M.) and/or assistants to inject a sclerosing solution into my affected veins for for the purpose of attempting to improve the symptomatology and appearance of my legs.

I understand that alternative treatments for varicose veins exist and that sclerotherapy may not be effective in every case.

The nature of the procedure to be performed has been explained to me, and I understand that among the risks are bruising, swelling of the leg, pain, itching, pigmentation, ankle swelling, phlebitis, skin necrosis (wound and scars), secondary telangiectasies (spider veins) and allergic reactions.

I am aware that in addition to the minor risks specifically described above, there are other risks that are very rare, such as infection, fainting, lower blood pressure, inflammation of the deep venous system with formation of a thrombus (clot), intraarterial injection or air embolism and nerve compression.

I hereby authorize Dr. Deborah Martin, M.D., C.C.F.P., (E.M.) and/or assistants to perform any other treatment, which may deem necessary should they encounter any unforeseen condition during the course of treatment eg. allergic reaction treatment.

I know that the practice of Medicine and Surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I have had sufficient opportunity to discuss my condition and proposed treatment and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent to the proposed treatment.

Print Name _____ Date _____	Print Name _____ Date _____
_____ _____	_____ _____
Signature (Patient or legal guardian) Doctor Signature	Signature (Patient or legal guardian) Doctor Signature

Varicose / Spider Vein Assessment

Last Name:_____ First:_____ Initial:_____ Date:_____

Address:_____ City:_____ Postal Code_____

Telephone: Home ( )_____ Work: ( )_____

Cell: ( )_____ OHIP Number:_____ Version Code:_____

Date of Birth: D____ /M____ /Y_____ Age:_____ E-mail:_____

Occupation:_____ Do you plan a pregnancy within the next 2 years?_____

Family Physician:_____ City:_____

How may we remind you of your appointment? ☐ Email ☐ No reminder please

How did you hear about us? MD Referral ☐ Internet ☐ Tradeshow ☐ Radio ☐ Which Station?_____

Friend ☐ Who?_____ Magazine ☐ ***Ask about our "refer a friend" program!***

You may not have Sclerotherapy if you are pregnant, breastfeeding, or three months after delivery.

Past Medical History

Major Illnesses (eg: cancer, HIV, hep. C, diabetes, surgery, etc.)_____

_____

Current Medications (dose not required) including vitamins_____

_____

Allergies_____

Do you suffer from any of the following symptoms?

☐ Burning, ☐ Aching, ☐ Swelling, ☐ Itching, ☐ Heaviness, ☐ Throbbing ☐ No symptoms

How many years have you noticed this problem? _____ Which leg is worse? ☐ Left ☐ Right

What percentage of your day is standing? _____ % Do you smoke? ☐ Yes ☐ No

Number of Children: _____ Exercise level ☐ Low ☐ Moderate ☐ High

Provide Details Below - Leave space empty if answer is No

Have you ever had trauma to your legs or pelvis?	Yes ☐	**Have you ever had**	
Have you ever received treatment for varicose veins?	Yes ☐	Phlebitis?	Yes ☐
Are you taking hormone pills, oral contraceptives (birth control)	Yes ☐	D.V.T. (leg clot)?	Yes ☐
Do you have Diabetes?	Yes ☐	Pulmonary Embolism (lung clot)?	Yes ☐
Cancer?	Yes ☐	other blood clots?	Yes ☐
Angina?	Yes ☐	Leg Ulcers?	Yes ☐
Peripheral Vascular Disease?	Yes ☐	Hepatitis?	Yes ☐
Thyroid Disease?	Yes ☐	H.I.V. (AIDS)?	Yes ☐

Does anyone in your family have a history of:

☐ Varicose Veins, ☐ DVT (leg clot), ☐ Blood disorders _____

Have you ever had dizziness or fainting after having blood drawn? ☐ Yes ☐ No

Do you own Compression Stockings? _____ (If so, please bring them with you for your next visit)

Do you wear them? ☐ Yes ☐ No

Do you have an extended health plan? _____ (if yes, your plan may cover stockings)