Ashfaq Siddiqui, MD, FACS

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GENERAL PROCEDURE CONSENT

I hereby request and authorize Dr. Siddiqui and/or such assistants as are designated by him to treat the condition that appears indicated by examinations and/or diagnostic studies. I consent to the procedures summarized as below.

MEDICAL CONDITION: I acknowledge that the undersigned physician has explained to me the nature of my condition or conditions.

- Varicose veins
- Infected/unhealing wound

PROCEDURE: I herby request and authorize that the following procedures be performed.

- o VNUS Closure
- o Phlebectomy
- o Wound debridement
- o Sclerotherapy

UNFORSEEN CONDITIONS: I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate procedures different from, or in addition to those we have discussed. I consent to the performance of additional operations and procedures which Dr. Siddiqui or his associates or assistants may consider necessary.

ANESTHESIA: I further consent to the administration of such anesthesia as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia.

BENEFITS, COMMON RISKS AND ALTERNATIVES TO PROPOSED TREATMENT PLAN: The undersigned physician has explained to me the nature of the proposed procedure and the risks associated with the procedure. The alternatives have also been explained to me along with consequences and common risk of these alternatives and/or of no treatment. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction.

SURGICAL RISKS: I have also been informed that there are risks attendant to the performance of any surgical procedure such as severe blood loss, infection, occasional nerve injury, superficial phlebitis, cardiac arrest and others, including death. I am aware that the practice of medicine and surgery and the administration of hospital care are not exact sciences. I agree that no guarantees have been made to me as the results of the procedure as described above.

DISPOSAL OF TISSUE: Surgically removed tissue may be examined and retained by Total Vein & Wound Care at Seena One for medical, scientific, or educational purposes. I consent to the disposal of these organs or tissues by the facility in accordance with customary practice.

Circle below:

I **DO/DO NOT/NA** consent to the admittance of observers/vendors in accordance with ordinary practices of the facility, to the use of closed-circuit television, taking of photographs and videotapes, and the preparation of drawings and similar illustrative graph material. I also consent to the use of such photographs and other material for scientific purposes, provided my identity is not revealed. I authorize and consent to the presence of students observing to participate in their clinical education.

I **DO/DO NOT/NA** authorize and consent to the presence of equipment representatives(s) for equipment and implants used during my surgery. I understand that the surgeon(s) may rely, in whole or part, upon the recommendations of the representative(s) regarding the involved equipment/implants.

PATIENT CERTIFICATION

I confirm that I have read or have had read to me, and understand the above document. I have been given the opportunity to have any of my questions answered to my satisfaction. I am of sound mind and am competent to make this decision and do so of my own free will and I have no further questions. I consent to the treatment or procedures as proposed by my physician.

Patient/Relative/Guardian Signature: _____

Date/Time: _____

Print Patient Name_____

Witness: _____ Date: _____

PHYSICIAN CERTIFICATION

I hereby confirm that I have explained the nature, purpose, benefits, risks and alternatives to the proposed procedure/operation, have offered to answer any questions and have fully answered such questions. I have explained in layman terms the substantial risk hazard, complications and consequences that are or may be associated with the treatments or procedure. I believe that the patient/relative/guardian fully understands what I have explained and has consented to undergo the proposed procedure/operation. The patient/guardian appears to be of sound mind, under no undue influence and competent to make this decision.

Physician Signature: _____

Date/Time: _____