

Thermavein Consent form

I understand that the purpose of this procedure is to reduce the appearance of small thread veins around the nose, cheeks and other areas of the face, neck, chest, breasts, back, shoulders or legs.

I understand that it may be used in combination with other treatments advised by the doctor.

I understand that a single procedure may fail to remove my vascular problems. Individual response may vary according to the degree of severity, follow up care and the body area being treated. For some individuals the treatment will not work or have a limited success.

I understand that the treatment may produce some discomfort and infrequently there is a need for pain relief topical medication. Sometimes this discomfort can cause a reflex eye watering and/or sneezing response.

Treated areas may have an urticarial response (similar to an insect bite or a cat scratch), this usually subsides quickly (3-5 days), however for some patients this may take longer. After Thermavein it can feel hot/burning sensation and sore at the treatment areas for a number of days or weeks.

Occasionally some of the thread veins may bleed during treatment and heal with tiny dot type scabs.

Colour changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin/vein lightening) may occur in the treated area. This can take many months to resolve, if at all.

Treatment can cause more thread veins to appear around treatment areas. Micro-scarring may occur, but is uncommon.

There are alternatives to Thermavein treatment including, but not limited to, sclerotherapy injections, IPL, laser treatments or no treatment at all.

I have been asked, at this time, whether I have any questions about the procedure, any further questions or queries prior to treatment. If I do, I will not sign this form and consult my doctor until my queries are addressed.

I understand the procedure, the benefits and possible side effects.

I accept the possible side effects and request that this procedure be performed on me by the

doctor. I agree to adhere to all of the advice and instructions given before, during and after the

procedure.

I certify that I have discussed all aspects of the treatment and have been given the opportunity to ask any questions or raise any concerns.

I confirm all questions have been answered implicitly to my satisfaction.

If required I hereby give permission to the doctor to take pre and/or post clinical photographs for diagnostic purposes and to enhance the medical record and for any anonymised marketing :

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| No | Yes |
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I give my consent to have Thermavein procedure(s) performed on me and the doctor has informed me, as a guidance, I will require the following number of treatments:

Please Select ▼

I hereby give my consent to be contacted for any relevant marketing or promotional events by the following methods :

Email Telephone SMS/Text No contact

* Patients Signature