

Δρ. Νεοφύτου Γιάννης  
Ιατρός Δερματολόγος  
Βασιλέως Κωνσταντίνου 6, 8021  
Πάφος  
Τηλ/Φαξ: 26950303

Dr Neofytou Yiannis  
Dermatologist  
6, Vas. Konstantinou, 8021  
Paphos  
Tel/Fax: 26950303

## CONSENT FORM- VEIN TREATMENT

Date : .....

Name: .....

The procedure to be performed is the Apogee Elite laser treatment for leg veins. 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 lasers 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, all options will be discussed with me. The area may appear reddish- purple in discoloration. 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.

I have been informed that local swelling, vesiculation, crusting, redness or even scarring, Hypopigmentation or Hyperpigmentation transient or permanent are possible risks and complications of this procedure.

Previous sun exposure or tanning increases the possibilities of complications to appear.

I understand that sun exposure after the treatment and not adhering to the post-care instructions provided to me may increase my chance of complications.

I understand that the treatments results are not guaranteed and that medicine is not an actual science there for the results may vary according to individual case/ patient.

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. Therefore, I authorize Dr. Neofytou Yiannis to perform laser vein therapy.

Patient:.....

Witness:.....