VEIN SCREENING FORM

Today's Date_____ Appointment Time_____
First Name_____ Last Name_____
Date of Birth_____ Age_____ Gender: Male Female
Address_____
Phone _____ home / mobile
e-mail _____
Family Physician_____
Insurance Provider_____
How did you hear about us? _____
Occupation:_____

PATIENT HISTORY: (please check or circle all that apply)

Do You have or have you ever been diagnosed with:

- ☐ Deep Vein Thrombosis (DVT) Leg: R / L
- ☐ Phlebitis Leg: R / L (Vein Redness/Tenderness)
- ☐ Saphenous Vein Reflux Leg: R / L
- ☐ Varicose Vein Problems Leg: R / L

Do you experience any of the following in you legs?

- ☐ Aching/Pain Leg: R / L
- ☐ Cramps Leg: R / L
- ☐ Heaviness Leg: R / L
- ☐ Itching/Burning Leg: R / L
- ☐ Restless Legs Leg: R / L
- ☐ Skin or Ulcer Problems Leg: R / L
- ☐ Swelling Leg: R / L
- ☐ Throbbing Leg: R / L
- ☐ Tiredness/Fatigue Leg: R / L
- ☐ Other: _____ Leg: R / L

Which of the following do you currently do to improve your leg vein symptoms:

Yes / No Elevation of Legs (please explain)
_____

Yes / No Medication for Pain (please explain)
_____

Yes / No Wear support hose (please explain)
_____

PAST MEDICAL HISTORY:

(please describe)
_____
_____

Are you diabetic? Yes/ No

Are you currently on blood thinners? Yes/ No

Do you have a heart murmur? Yes/ No

Do you have any artificial valves? Yes/ No

Medications

_____
_____
_____

Allergies

(if any please describe)

_____
_____
_____

FAMILY HISTORY: Has a member of your family (not include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		Family Member
Yes / No	Deep Vein Thrombosis	_____
Yes / No	Blood Coagulation Disorder	_____
Yes / No	Stroke, Heart Attack, or Pulmonary Embolism (please circle)	_____
Yes / No	Varicose Veins	_____
Yes / No	Vein Stripping	_____

VEIN TREATMENT HISTORY:
Have you ever been treated for varicose veins with the following?

- ☐ Laser Therapy (Spider Veins) Leg: R / L
- ☐ Phlebectomy Leg: R / L
- ☐ RF Ablation (benefit) Leg: R / L
- ☐ Sclerotherapy Leg: R / L
- ☐ Vein Stripping Surgery Leg: R / L

PERSONAL ACTIVITIES LIST:
(please circle all that apply)

Yes / No My work requires me to stand for prolonged periods of time.

Yes / No My work requires me to sit for prolonged periods of time.

Yes / No I exercise regularly.

Yes / No I smoke

Yes / No I have been pregnant before. Number of pregnancies? _____

Is there any chances that you are pregnant right now? _____

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YOUR TREATMENT GUIDE

For varicose veins, treatment options may include:

☐ **Sclerotherapy** is a simple procedure that eliminates spider veins and some varicose veins by injecting the affected vein with a "sclerosing agent" solution that causes them to **collapse and disappear**. Most sclerotherapy patients experience significant clearing of the veins and positive results. The number of veins injected in one session is variable, depending on the size and location of the veins, and the patient's overall medical condition. Several treatments usually are required to achieve desired results. In general, spider veins respond to treatment in **three to six weeks**, and larger veins respond in **three to four months**. Sclerotherapy can eliminate the pain and discomfort of varicose veins and helps prevent complications such as venous hemorrhage and ulceration. It is also frequently performed for cosmetic reasons.

- ☐ Right leg
- ☐ Left leg

☐ **Foam sclerotherapy (Varithena)** is a variation of sclerotherapy performed with or without ultrasound guidance that involves the injection of a foaming agent mixed with a sclerosing agent. The **foaming agent moves blood out of the vein** so the sclerosing agent will have better contact with the vein wall. Recovery time is minimal, typically 2 days.

- ☐ Right leg
- ☐ Left leg

☐ **Micropuncture, micro-incision or stab phlebectomy** is performed in office setting or an outpatient surgery center. The physician makes several tiny incisions and uses a surgical instrument or a large needle to hook the problem vein through the opening. The vein is then removed a tiny piece at a time.Recovery is typically 4 weeks.

- ☐ Right leg
- ☐ Left leg

☐ **Endovascular radiofrequency ablation (RFA)** are **minimally invasive** procedures for varicose vein treatment targeting the venous reflux in the saphenous veins. A catheter is guided by ultrasound and inserted into the vein. A highly concentrated beam of radiofrequency is sent through the tip of the catheter, which **destroys the abnormal varicose vein and the pain caused by it**. Ablation involves minimal discomfort and a brief recovery typically 2 weeks for most patients.

- ☐ Right greater saphenous vein
- ☐ Left greater saphenous vein
- ☐ Right short saphenous vein
- ☐ Left short saphenous vein

Pre-op Instructions for all Vein Procedures

You will be seeing the provider prior to the procedure if you have any additional questions the day of procedure.

It may be helpful to have someone drive you to and from your procedure appointment.

Please ***no caffeine*** the day of your procedure if you are having an ablation. You may have caffeine afterwards.

Valium can be prescribed ***if*** you feel you need it. Please inform us two days prior to your procedure to allow for it to be sent and filled by your pharmacy. If you have requested valium, please remember to take your first valium 30 minutes prior to the procedure check-in time. You will take the second pill upon arrival.

Make sure you eat as you normally would prior to your procedure. Please drink plenty of water, the more the better.

You will be required to wear compression stockings for 14 days (or as instructed) after your procedure. If you do not yet have a pair, we do offer a selection for purchase in our office.

You will have an Ace bandage placed on your leg after the procedure, please wear appropriate pants to accommodate for this, loose fitting or sweat pants are best.

Travel is restricted until 14 days after the procedure.

Please call 440-600-7675 with any questions.

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1. I consent that my visit will be a telemedicine visit with _____.
2. I have the right to withdraw consent for my telehealth visit at any time without affecting my future care or services.
3. I understand that the video conferencing technology will be used for my consultation. I understand that this consultation will not be the same as an in-person visit with my healthcare provider due to the fact that I will not be in the same room as my healthcare provider. My healthcare provider will provide the same standard of care for my telemedicine visit and may require an in-person visit for a complete assessment of my condition.
4. The potential risks to my telemedicine visit include but are not limited to interruptions, unauthorized access, and technical difficulties. I understand that the video conference can be discontinued by myself or my healthcare provider if the videoconferencing connections are not adequate to perform the consultation.
5. I understand that there will be no recording of my telemedicine visit by either party. My protected health information also applies to telehealth visits and information disclosed will remain confidential. I understand that healthcare information may be shared with individuals for the purpose of scheduling and billing.
6. I choose to participate in a telemedicine visit, understanding that I have the alternative to choose an in-person visit at Solon Vein Clinic.
7. I understand that in an emergency, my telemedicine provider has the responsibility of advising me to seek an in-person assessment and the provider's responsibility will conclude upon the termination of the telemedicine appointment.
8. I understand that I will be billed for telemedicine services the same as I would be for an in-person visit.
9. I have read this document carefully, with an understanding of the risks and benefits of the telemedicine consultation. My questions have been answered and I hereby consent to participate in a videoconferencing visit with an understanding of the previously stated terms.

Name: _____ Date:_____

Signature:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

D.O.B_____

Signature_____ Date_____