

PRE-OPERATIVE ABLATION INSTRUCTIONS

READ ALL INSTRUCTIONS CAREFULLY

* If you will need a driver, please make the necessary arrangements to be driven to and from your appointment.
* Arrive 15 minutes prior to your scheduled appointment.
* If the doctor prescribed you any pain medications, take your prescriptions after you sign your consents.
* Be sure to take your regularly prescribed medications the day of surgery unless otherwise instructed by your surgeon or nursing staff. This includes blood thinners and aspirins.
* Please wear loose fitting clothing; such as jogging pants, gym shorts, or a flowing skirt.
* Wear loose fitting shoes (flip flops or open sandals) to accommodate the compression bandages on foot after procedure.
* Vessels can constrict or get smaller making it difficult to get access to the vein, so to help prevent this please make sure you;
	+ **Do not** wear your compression stockings the day of the procedure.
	+ When you check-in the day of the procedure, do not sit. Continue to stand and/or walk around.
	+ **NO CAFFEINE!**  It is important to eat a good meal and drink plenty of fluids prior to surgery.
* ***We ask that you give 72 hours’ notice if for any reason you cannot keep your appointment. We are setting aside limited time and scheduled personnel for your procedure including: physicians, nurses, vascular ultrasound technologists and other office staff, in which a considerable cost in incurred. Therefore, if you are unable to keep your scheduled appointment time for the procedure, this cost may be your responsibility.***
* Please see the attached Treatment Plan for your scheduled date(s) and time(s).

**I have read and understand the above instructions. I feel that all my questions have been answered at this time. I understand that my procedure(s) are scheduled for the date(s) on the attached Treatment Plan. In the even I do NOT arrive at the given time, I understand that my wait time could be extended, or I could be asked to reschedule.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/ \_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/ \_\_\_\_\_\_\_

Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/ \_\_\_\_\_\_\_