

PRMC DISCLOSURE AND CONSENT FOR ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPH

TO THE PATIENT: *You have the right, as a patient to be informed about your condition and the recommended endoscopy procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent for the procedure.*

I voluntarily request Dr. _____ as my physician and such assistants as he may designate to treat my condition which has been explained to me as _____

I understand that the following surgical, medical and diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures; **Endoscopic Retrograde Cholangio-Pancreatograph (ERCP)** _____

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand this procedure involves passage of a flexible fiberoptic instrument through my mouth and back of my throat into the first portion of my small intestine (duodenum). The opening from the bile and pancreatic ducts into the duodenum is identified and a small plastic tube (cannula) is then passed through the endoscope into this opening. Contrast material (dye) is then injected into the bile and or pancreatic duct and x-rays are taken to study the ducts.

I understand that possible complications from this procedure include, but are not limited to **infection, tearing and sometimes perforation of the bowel, pancreatitis due to irritation of the pancreatic ducts by dye and infection of the bile duct.** These complications are very uncommon but may require surgery or additional medical treatment.

If necessary, I also agree to increasing the opening of the bile duct into the duodenum by electrical cauterization and the removal of bile duct stones, though both are accompanied by slightly greater risk of complication, including **bleeding and perforation.** Rarely transfusions and or surgery may be required.

If necessary, I also agree to the placement of either a permanent or temporary small plastic tube (stent) into my bile or pancreatic duct to aid in drainage of either bile or pancreatic juice through a narrowing discovered at the time of this exam.

I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedure. I realize the anesthesia may have to be changed possibly without explanation to me. I understand that certain complications may result from the use of any anesthetic including **respiratory problems, drug reaction, paralysis, brain damage or even death.** Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I understand and agree that photographs may be taken of the inside of my stomach or intestine during this procedure.

I (DO) pt _____ witness _____ (DO NOT) pt _____ witness _____ consent to the use of blood and blood products as deemed necessary. I understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

I understand that no warranty or guarantee has been made to me as to the result of the procedure.

I have been given an opportunity to ask questions about my condition, possible alternative procedures, the procedures to be used, and the risks and hazards involved, and believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

DATE _____ TIME _____
PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON SIGN (RELATIONSHIP)

WITNESS (Print and signature) WORK ADDRESS CITY, STATE, ZIP CODE

PHYSICIAN CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the proposed procedure. I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian understands what I have explained and has consented to undergo the proposed procedure.

Physician signature _____ Date _____ Time _____