ERCP involves passing a lighted flexible tube (duodenoscope), under x-ray control (fluoroscopy), through the mouth to the first part of the first small intestine (duodenum). A plastic tube is then passed through the duodenoscope to drain the pancreas, liver, and gallbladder. If there is an obstruction of the bile duct, and/or stones noted, a small cut (sphincterotomy) will be done through the duodenoscope, and a tube (stent) is sometimes placed to relieve the obstruction. Stones may also be removed through the sphincterotomy site. Additionally, small pieces of abnormal-appearing tissue (biopsy) may be taken during the procedure. Medication may be given to you by vein (intravenous) to minimize discomfort and pain during the procedure.

Patient’s Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of endoscopic retrograde cholangio-pancreatography have been discussed with me and may include but are not limited to:

- adverse reaction to sedation
- bleeding
- gagging/discomfort
- gassy discomfort/bloating
- inflammation of the liver
- inflammation of the pancreas
- pain
- perforation

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I have arranged for transportation after my examination is complete.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, M.D., with associates or assistants of his or her choice, to perform ERCP on _______________________.

(patient name)
I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_______________________________                  _______________________________
Patient or Legal Representative Signature/Date/Time                                                   Relationship to Patient

_______________________________                      _______________________________
Print Patient or Legal Representative Name                                                                           Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____________________________
Physician Signature/Date/Time

_______ copy given to patient                                                 _______ original placed in chart
initial                               initial

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).