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ERCP Patient Consent Form

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____

I, the undersigned consent for an ERCP**.** Endoscopic Retrograde Cholangiopancreatography (ERCP) is a specialized technique used to study the ducts (drainage routes) of the gallbladder, pancreas, and liver. This procedure involves the insertion of an endoscope through the mouth and into the first part of the small intestine where dye can be injected into the ducts. It is recommended to diagnose and often treat conditions such as gallstones, inflammatory strictures (scars), leaks (from trauma and surgery), and cancer.

Participation in this procedure carries risks including, but not limited to sore throat, and abdominal pain. 5-10 people out of every 100 can experience pancreatitis causing abdominal pain requiring a hospital stay. Rarely it can be more severe needing surgery, ICU and even death. 1-2% of people can experience bleeding from a sphincterotomy. Rarely infections, perforation of the intestine, and reactions to anaesthesia can occur

ERCP can provide crucial information about the pancreas, bile ducts, and gallbladder and can also treat certain conditions immediately, avoiding the need for more invasive surgery. Alternatives to ERCP include magnetic resonance cholangiopancreatography (MRCP), endoscopic ultrasound (EUS), or surgical exploration with their risks and potential pitfalls.

I have received and understand the instructions for preparing for an ERCP. I understand that I need to fast on the day of the procedure (at least 6 hours fasting for food and at least 3 hours fasting for clear fluids). I have also received instructions about how to manage any blood thinners or medications for diabetes and weight loss around the time of the procedure.

I understand that sedation will be used for the procedure and that I should not drive, operate machinery or make important decisions until the following day. I understand that I must be discharged into the care of a responsible adult following the procedure.
I understand that I may withdraw this consent at any time or on the commencement of procedure or treatment. Additionally, that certain clinical information may be required as part of statutory/state health department requirements, (ie: cancer registry). I understand that clinical images may be taken as part of my care and stored within my medical record. These images will not be used for any other purpose without my permission.

Patient Acknowledgment:
I understand that my doctor will be available to answer any further questions I may have at the time of the procedure. I understand the information provided and voluntarily consent to proceed with the ERCP. I consent to any necessary treatment or interventions that may arise during the procedure, such as a sphincterotomy, or insertion of a biliary or pancreatic stent.

In extremely rare circumstances a blood transfusion may be required following an endoscopic procedure. Please specify if you do not wish to have a blood transfusion.

☐ I DO NOT consent to the administration of blood or blood products

Signatures:

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____