South Bay
Gastroenterology
Medical Group

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INFORMED CONSENT FOR ERCP

1. I,_____authorize Dr. _____ and any assistant(s) he/she deems necessary to perform ERCP (Endoscopic Retrograde Cholangio-Pancreatography) with possible dilatation of stricture, stent placement, sphincterotomy, and_____.

2. I understand this procedure involves the following: Passage of digital optic instrument to allow the physician to inject contrast material (dye) and visualize the biliary and/or pancreatic ducts, possible incision and enlargement of the bile duct opening using an electric current. Conscious sedation and pain relieving medication(s) may be given to minimize discomfort and relax me for the procedure. These medications may cause localized irritation and/or a drug reaction may occur.

3. RISKS: Possible complications of this procedure include but are not limited to: Bleeding, tearing or perforation of the esophagus, stomach or small intestine (1-3% occurrences), pancreatitis (5-30% depending on age). Enlargement of the bile duct opening (papillotomy) increases the risk of bleeding to 5%. These complications, should they occur may require surgery, radiologic procedures, hospitalization, and/or a transfusion. A 1% chance of other complications which include infection, over sedation, irregular heartbeat and contrast reaction. The procedure cannot be completed because of technical reasons in about 10% of cases. Other risks which can be serious and possibly fatal include: difficulty breathing, heart attack and stroke. These risks are extremely rare but may occur. Death from a procedure related complication occurs in approximately 1 out of a 1,000. I understand that there are no guarantees regarding the results of this procedure. Alternatives are:_____.

4. I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, **ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM**.

_____	_____	_____
Witness	Patient/Responsible Party	Date/Time

7. PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the patients' questions. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____	_____
Physician's Signature	Date/Time