Asheville Gastroenterology Associates

ERCP with Manometry of the Biliary and Pancreatic Ductal Systems and Possible Sphincterotomy

This consent is for endoscopic injection of x-ray dye into the biliary and pancreatic ductal system (ERCP) and measuring pressures in the biliary and pancreatic ductal systems (manometry). This consent is also for cutting open the common bile duct and pancreatic duct (endoscopic sphincterotomy).

Patient Name _____ Date _____ Time _____

Endoscopic injection of x-ray dye into the biliary system and pancreatic ductal systems (ERCP), measuring pressure within the bile duct and pancreatic duct (manometry), and cutting open the bile duct and pancreatic duct (sphincterotomy).

The nature of this procedure, the benefits of the procedure, and possible alternative methods of diagnosis and treatment (including the option of doing nothing) have been explained to me. I have not been guaranteed a specific result from these procedures. The risk of injury, despite precautions has been reviewed with me.

I understand that the more common risks, but not all of the risks of this procedure are:

1. Pancreatitis (inflammation within the pancreas which can be severe and life-threatening).
2. Perforation (making a hole) in the bowel, bile duct, or pancreatic duct.
3. Hemorrhage (severe bleeding) that could require blood transfusions.
4. Infection, including abscess.
5. Adverse reactions to x-ray dye and medications that are given for the procedure.
6. Diabetes, which could require insulin therapy.
7. Chronic disability.
8. Death is a remote possibility.

I further understand that emergency surgery and blood transfusions could be needed to correct the above complications and I authorize my physician to proceed with such emergency surgery as he may determine is necessary.

My questions regarding ERCP with Manometry of the Biliary and Pancreatic Ductal Systems and Possible Sphinctertomy have been satisfactorily answered and I consent to have Dr. _____ _____, and such assistants as he may designate, to perform upon _____ these Endoscopic Procedures.

(Myself or name of patient)

_____ _____

Print Name | Signature of Patient or Person Authorized to Consent for the Patient

_____ _____

D.O.B. | Witness