MEDICAL RECORD	INFORMED CONSENT FOR PERFORMANCE OF PROCEDURE and REQUEST FOR SEDATION/ANESTHESIA

1. Name of Procedure: Endoscopic Retrograde Cholangiopancreatography (ERCP); sphincterotomy, stent placement, dilation &/or stone removal
   For: _____ Diagnosis _____Therapy _____
2. Condition to be treated: To examine the esophagus, stomach, upper intestine, bile ducts, and/or pancreas for abnormalities. Treatment(s) may be performed depending on the findings.

PROPOSED PROCEDURE

3. Description of the procedure: A flexible scope is inserted in through the mouth to inspect the upper gastrointestinal tract, bile ducts, and/or pancreas for abnormalities usually under sedation or anesthesia. A catheter is placed in the duct and dye injected to look for stones/strictures. The sphincter may be cut, ducts may be dilated and stents may be placed to facilitate bile drainage.
3. Risks of the procedure: Inability to complete procedure, tearing tissue, bleeding, infection, inhalation of gastric contents, allergic reaction, IV site irritation, unstable vital signs, depressed breathing, pancreatitis, cardiac arrest and death
4. Intended results of the procedure: Treatment of gall stones in bile ducts or strictures. Symptom alleviation.

ALTERNATIVES TO PROPOSED PROCEDURE

5. Recognized alternatives to the proposed procedure: Dissolving medications.

6. Risks and benefits associated with the alternatives:
   Risk: Medication side effects and stone reformation.
   Benefit: No complications from procedure.

7. Risks associated with not undergoing any treatment or procedure: Possibly unable to diagnose or treat condition properly. Life threatening infection.

8. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of Tripler Army Medical Center.

9. Exceptions to surgery or anesthesia, if any are: _____ _____None
   (If "none", so state)

10. I request the disposal by the medical facility of any tissues or parts which it may be necessary to remove.

11. I understand that photographs and videos may be taken of this operation, and that they may be viewed by various personnel. I consent to the taking and hard copy and electronic storage of such pictures.

12. COUNSELING PROVIDER: I have counseled this patient regarding the condition to be treated, the description of the proposed procedure, the intended and anticipated results and the risks of the proposed procedure, alternative treatments, if any, the risks and benefits of the alternative treatments, and the risks of undergoing no treatment.

_____
Signature of Counseling Physician/ Dentist

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name –last, first, middle, ID no. (SSN or other); hospital or medical

Medical Record