This form is provided as a courtesy and should not be construed as legal advice

PATIENT INFORMED CONSENT

1. **OPERATION OR PROCEDURE AND ALTERNATIVES:**

I _____, (patient or guardian) authorize **Doctor Patel**, associates and assistants of his or her choosing to perform the following operation or other procedure: ERCP (Endoscopic Retrograde Cholangiopancreatogram) with possible sphincterotomy, dilatation or stent placement. I understand the reason for the procedure is: _____

_____

Alternatives include: Percutaneous transhepatic cholangiogram .

2. **RISKS:** This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of the significant risks of this particular procedure are:

• Bleeding • Perforation (hole) requiring surgery • Cardiac or pulmonary problems related to stress of the
• Infection • Pancreatitis procedure or the medication used for the sedation

I also understand that more common risks of any procedure include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These risks are serious and possibly fatal.

3. **ANESTHESIA:** The administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services except: none . (If none, write “none”)

4. **ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of surgery, I authorize him or her to perform such other procedure as deemed necessary except: none . (If none, write “none”)

5. **RESULTS NOT GUARANTEED:** I understand that no guarantee or assurance has been made as to the results of the procedure and that it **may not sure the condition.**

6. **PATIENT’S CONSENT:** I have read and fully understand this consent form and understand I should not sign this form if all items, including all 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. I have no further questions.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURES OR ANY QUESTIONS CONCERNING THEM, ASK YOUR PHYSICIAN BEFORE SIGNING THIS FORM.

Continued On Back Side, Turn Over →

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

_____	_____
Witness	Patient/Responsible Party

		AM
_____	_____	PM
Date	Time	

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

			AM
_____	_____	_____	PM
Physician's Signature	Date	Time	