## Space for Medical Institution Name and Logo

2001 ינואר/GEODS/5110/ERCP/0051 ט

# טופס הסכמה: הדגמה אנדוסקופית של דרכי המרה והלבלב
# CONSENT FORM: ERCP – ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY

ERCP is an endoscopic visualization technique used for diagnosing and/or treating diseases of the bile ducts and pancreas. The endoscope is a flexible tube containing optic fibers enabling visualization, and conduits through which various instruments can be introduced for diagnosis and treatment purposes. The length of the endoscope is approximately 1.20 meters, and its diameter is approximately 1 cm. Before the insertion of the endoscope, sedatives and/or local anesthesia are administered to the patient. The procedure is usually performed with the patient lying on his/her stomach. The endoscope is inserted through the mouth. The bile ducts and pancreas are demonstrated using the injection of contrast medium and x-ray films. If stones or narrowing of the bile ducts are identified, the stones can be removed and the narrowing dilated by cutting open the bile ducts and pancreas and inserting the appropriate instruments which enable extracting the stones and improving the drainage of the bile ducts and pancreas. The insertion of a stent may be necessary to ensure continued drainage. The duration of the procedure is usually 30 to 90 minutes. During the procedure there is a certain sense of discomfort. Following the procedure, hospitalization may be required for 24 hours, for observation.

Name of Patient: ________________ ________________ ________________ ________________
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. ________________ ________________
Last Name First Name
regarding the need to perform a diagnostic and/or therapeutic ERCP, including the removal of stones, dilation of narrowed ducts and incision of the bile ducts and pancreas (henceforth: "the primary treatment").

I have been given an explanation concerning diagnostic and therapeutic alternatives, their advantages and disadvantages, their side effects and possible complications.

I hereby declare and confirm that I have been told that the primary treatment is accompanied by a sense of discomfort. In addition, I have been given an explanation concerning the possible complications of any endoscopic procedure, including hemorrhage or damage to the gastrointestinal tract, which in some cases may necessitate surgical treatment. It is also possible that the teeth will be damaged during the insertion of the device through the mouth. I have been given an explanation concerning possible complications, including: pancreatitis (pancreatic infection) and infrequently, cholangitis (bile duct infection). Possible infrequent complications when the bile ducts are cut open include hemorrhage and perforation of the duodenum. A rare complication of ERCP, with or without incision of the bile ducts, is death.

I hereby give my consent to perform the primary treatment.

In addition, I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary treatment, or immediately following it, the need to extend or modify the procedure or to perform additional or different procedures may arise in order to save my life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time but whose significance has been made clear to me. I, therefore, also give my consent to such an extension, modification or performance of different or additional procedures, including additional surgical

procedures, which the institution's physicians deem essential or necessary during the primary treatment or immediately following it.

I hereby also consent to the administration of sedatives and local anesthesia after having been told that the use of sedatives may cause, in rare cases, respiratory disturbances and disruption of the heart's activity, especially in patients with cardiac and respiratory diseases, and that there is a possible risk of various degrees of allergic reactions to the anesthetic drug.

I know and agree that the primary treatment and any other procedure will be performed by any designated surgeon, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

| ____________________ | ____________________ | ____________________ |
|---|---|---|
| Date | Time | Patient Signature |

| ____________________ | ____________________ |
|---|---|
| Name of Guardian (Relationship) | Guardian Signature (for incompetent, minor or mentally ill patients) |

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required, and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

| ____________________ | ____________________ | ____________________ |
|---|---|---|
| Name of Physician | Physician Signature | License No. |

* Cross out irrelevant option.