Please read and sign the consent forms and complete the patient information forms.

We must receive these completed forms before your Procedure can be performed.

You can mail these forms to the Waterbury address Listed above or they may be faxed to our office at 203-573-1739.

Thank You.
INSTRUCTIONS FOR ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

1. You are to have nothing to eat or drink after midnight the night before the procedure.
2. Someone must be available to drive you home following the procedure.
3. Aspirin products, Ibuprofen, Aleve, iron tablets and blood thinners (i.e. Coumadin, Heparin, Naprosyn) must be discontinued one week before the procedure.
4. It is important to let the doctor know if you have any allergies.
5. The following medications should be taken with a small sip of water before going for your procedure.

_____________________________________________________________________________________

Any other medications should not be taken until after the procedure.

6. If you are diabetic, you are to take your medication as follows:

_____________________________________________________________________________________

7. Please bring with you a list of all medications that you take on a regular basis.

Your procedure is scheduled for :_________at:____________________ Hospital by Dr.__________.

ST. MARY’S HOSPITAL: 56 Franklin St. Waterbury, CT.
Please report to the admitting office on the second floor.
THE HOSPITAL WILL CALL YOU THE DAY BEFORE YOUR PROCEDURE WITH YOUR TIME.
The following is a list of products containing aspirin, aspirin-like compounds, Ibuprofen, and Naproxen sodium. **PLEASE DO NOT TAKE THESE PRODUCTS FOR ONE WEEK PRIOR TO YOUR PROCEDURE.**

### Prescription products containing aspirin or aspirin-like compounds:

<table>
<thead>
<tr>
<th>Product</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actron</td>
<td>Norgesic &amp; Norgesic Forte Tablets</td>
</tr>
<tr>
<td>Cataflam</td>
<td>Orudis</td>
</tr>
<tr>
<td>Celebrex</td>
<td>Percondan and Percondan-Demi Tablets</td>
</tr>
<tr>
<td>Darvon Compound 65</td>
<td>Plavix</td>
</tr>
<tr>
<td>Disalcid Capsules/Tablets</td>
<td>Ponstel</td>
</tr>
<tr>
<td>Dolobid</td>
<td>Relafen</td>
</tr>
<tr>
<td>Easprin Tablets</td>
<td>Robaxiral Tablets</td>
</tr>
<tr>
<td>Empirin with Codeine Tablets</td>
<td>Salflex Tablets</td>
</tr>
<tr>
<td>Equagesic Tablets</td>
<td>Soma Compound Tablets</td>
</tr>
<tr>
<td>Fiorinal with Codeine Capsules/Tablets</td>
<td>Synalgos-DC Capsules</td>
</tr>
<tr>
<td>Halfprin</td>
<td>Talwin Compound Tablets</td>
</tr>
<tr>
<td>Lodene</td>
<td>Toradol</td>
</tr>
<tr>
<td>Lortab ASA Tablets</td>
<td>Trilisate Tablets/Liquid</td>
</tr>
<tr>
<td>Magsal Tablets</td>
<td>Vioxx</td>
</tr>
</tbody>
</table>

### Prescription Products Containing Ibuprofen:

<table>
<thead>
<tr>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motrin Tablets</td>
</tr>
<tr>
<td>Children’s Advil Suspension</td>
</tr>
<tr>
<td>Children’s Motrin Suspension</td>
</tr>
</tbody>
</table>

### Prescription Products Containing Naproxen/Naproxen Sodium:

<table>
<thead>
<tr>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaprox/Anaprox DS Tablets</td>
</tr>
<tr>
<td>Naprelan</td>
</tr>
<tr>
<td>Naprosyn Suspension/Tablets</td>
</tr>
</tbody>
</table>
Nonprescription Products Containing Ibuprofen:

- Advil Caplets/Tablets
- Advil Cold, Sinus Caplets
- Bayer Select Ibuprofen Pain Relief Formula Caplets
- Dristan Sinus Caplets
- Haltran Tablets
- Ibuprofen Caplets/Tablets
- Midol IB Tablets
- Motrin IB Caplets/Tablets
- Nuprin Ibuprofen Caplets/Tablets
- Sine-Aid IB

Non-Prescription Products Containing Aspirin and/or Aspirin-like Compounds:

- Alka-Seltzer Antacid/Pain Reliever
- Effervescent Tablets
- Alka-Seltzer Plus Cold Medicine Tablets
- Anacin Caplets/Tablets
- Anacin Maximum Strength Tablets
- Arthritis Pain Formula Tablets
- Arthritis Strength Bufferin
- Ascriptin Caplets/Tablets
- Ascriptin A/D Caplets
- Aspergum
- Bayer Aspirin Caplets/Tablets
- Bayer Children’s Chewable Tablets
- Bayer Plus Tablets
- Maximum Bayer Caplets/Tablets
- 8 Hour Bayer Extended Release Tablets
- BC Powder
- BC Cold Powder
- Buffaprin Caplets/Tablets

- Bufferin Arthritis Strength Caplets
- Bufferin caplets/Tablets
- Cama Arthritis Pain Reliever Tablets
- Doan’s Pills Caplets
- Ecotrin Caplets/Tablets
- Empirin Tablets
- Tablets Excedrin Extra Strength Caplets/Tablets
- Midol Caplets
- Mobigesic Analgesic Tablets
- Norwich Tablets
- P-A-C Analgesic Tablets
- Pepto Bismol Liquid/Tablets
- Sine-Off Tablets, Aspirin Formula
- St. Joseph Adult Chewable Aspirin
- Therapy Bayer Caplets
- Trigesic
- Ursinus Inlay-Tabs
- Vanquis Analgesic Caplets

Non-Prescription Products Containing Naproxen Sodium:

- Aleve Caplets/Tablets
ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

This is an explanation of the procedure you are going to have. After you have read it you will be asked to sign a permit giving the doctor permission to perform the test.

ERCP is a test used to examine the pancreas, bile ducts, gall bladder and liver when an abnormality is suspected based on history, physical examination, blood tests, or x-rays. An alternative would be an abdominal operation or a transhepatic cholangiogram (performed by injecting dye through a needle inserted into the liver). The x-rays obtained by ERCP are superior to those obtained by other types of x-rays.

The procedure is done in the x-ray department and takes 1½ hours. You will be asked to have nothing to eat or drink after midnight the night before the test. The doctor will tell you whether to take any of your regular medications. When you arrive for the test the nurse will check your pulse and blood pressure and insert an intravenous line into a vein so that you can receive medications. IT IS IMPORTANT TO LET THE DOCTOR KNOW IF YOU HAVE ANY ALLERGIES. Your throat will be sprayed with an unpleasant tasting liquid which numbs the throat so that you will not gag. Medications will be given through the intravenous line to help relax and sedate you.

A thin fiberoptic tube called a duodenoscope will be passed through the mouth and the back of the throat into the upper intestinal tract. A small plastic tube (cannula) is guided through the duodenoscope and into the opening from the bile duct and pancreas. Dye is injected into the ducts and x-rays are taken. If necessary, a different cannula called a papillotome may be inserted into the bile duct and an incision can be made to remove stones or relieve a stricture. Other types of cannulas such as a basket (for removing stones from the duct) or stents (to allow pancreatic juice or bile to flow properly into the intestine) may be used.

As with any test there may be complications. We want you to be aware of these possibilities:

- Inflammation of the pancreatic ducts (pancreatitis) may occur from irritation by the dye.

- Perforation or a tear in the lining or the throat, esophagus, stomach, or duodenum may occur. This may be managed by simply aspirating the fluid until the tear closes or may require surgery.

- A blood stream infection may occur if there is blockage of the bile ducts.

- Inflammation of the vein (phlebitis) may occur from the intravenous line or the medications. This may produce a tender lump which may last for several weeks to months. This eventually goes away.

- Allergic reactions, drug reactions, and complications from unrelated diseases such as heart attack or stroke may occur.

- Extremely rare is the possibility that death may occur.

If you have any questions about this test, they will be answered for you before you sign this form and the hospital permission form. Our office staff will be happy to discuss the cost of this test, our method of billing, and insurance coverage.

I understand the benefits and possible risks associated with this procedure and give permission to Dr._________________ to perform the above test.

PRINT PATIENT NAME:_____________________________________________________________________________

PATIENT SIGNATURE:_________________________________________DATE:________________________

WITNESS:_______________________________________________________________________________________
SUMMARY OF NOTICE OF PRIVACY PRACTICES

By Law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

Please be advised that we may:

1. Call your name when the doctor is ready to see you.
2. Leave test results or messages on your answering machine.
3. Take your charts out of the office for dictation, review, or to see you in our satellite office.
4. Call your place of employment and ask to speak with you.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative (“Agent”) of the Patient acknowledges that he or she personally received a copy of the DIGESTIVE DISEASE CENTER Notice of Privacy Policies on the date below.

Signature:________________________________________            Date:__________________________

Patient (print)_________________________________________________________________________

Information about Agent (attach appropriate documentation):

Agent:______________________________________________________________________________

Title:________________________________________________________________________________

I grant permission to DIGESTIVE DISEASE CENTER to share my Protected Health Information with the following individuals:

Name:___________________________Phone#________________Relationship to Patient____________

Name:___________________________Phone#________________Relationship to Patient____________

Name:___________________________Phone#________________Relationship to Patient____________

Signature of Patient:________________________________________            Date:__________________________
(PRINT) NAME: ___________________________________ DOB: ______________

E-MAIL ADDRESS: ______________________________________________________

Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino

Race:
□ White
□ Black or African American
□ Asian
□ American Indian or Alaska Native
□ Native Hawaiian or Pacific Islander
□ Unknown
□ Hispanic
□ Mixed Racial Heritage (two or more race)

Signature: _______________________________ Date: ________________________