Braemar Hospital

Your choice for excellence

BRAEMAR HOSPITAL TO AFFIX
PATIENT DETAILS LABEL HERE

ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (ERCP) AND ENDOSCOPIC ULTRASOUND (EUS) BDH-ES/03

As advised by your Surgeons rooms

Date of Admission: ..... **Time of Admission:** .....

Nothing to eat from: ..... Nothing to drink from: .....

Please complete this form online:

1. Once completed, save the completed form as a pdf
2. Email the pdf to admissions@braemarhospital.co.nz at least 1 week prior to your admission

Legal Surname: Miss ◉ Ms ○ Mrs ○ Mr ○ Dr ○ ○

Legal First Names: Preferred Name:

Date of Birth: Country of Birth:

Gender/Pronouns: Are you a permanent NZ resident?: Yes ○ No ○

Ethnicity:

Home Address:

Postal Address:
(if different to home)

Phone 1: Phone 2:

Email: Email Invoice? Yes ○ No ○

Surgeon or Specialist:

GP's Name: Practice:

Next of Kin

Name: Relationship:

Address:

Contact Phone Numbers:

Contact Person (if different from above)

Name: Relationship:

Address:

Contact Phone Numbers:

Medical Insurance Company: Approval Number:

ACC Approval Number:

Have you been treated in this hospital previously? Yes ○ No ○ Name previously used:

Do you require "Boarder" accomodation for an adult with a child patient? Yes ○ No ○

Braemar Hospital is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.

Information and Consent Form

ERCP

ERCP (Endoscopic Retrograde Cholangio-Pancreatography) is a procedure where a flexible scope is inserted via the mouth, down the oesophagus, through the stomach and into the upper part of the small bowel. When you enter the procedure room, you will be asked to lie flat on your back on an x-ray table, this is where the procedure will be performed. Once the scope is in position, a thin, plastic hollow tube is passed through the scope into the opening to the pancreatic and/or bile duct. X-ray dye is injected into the ducts through the tube and, under x-ray guidance, the biliary and pancreatic ducts and gallbladder are identified. The images are passed from the scope onto a screen so your doctor can view these areas. As with all medical procedures, there are some risks of complication.

Complications of ERCP occur in approximately 8-9% of procedures and consist of:

- Inflammation of the pancreas (Pancreatitis), which occurs in 3-5% of cases. 80-85% of pancreatitis will be mild or moderate. 15-20% will be severe. Pancreatitis is caused by the x-ray dye infiltrating some of the cells of the pancreas. If this occurs, you will be monitored closely and you will need to remain in hospital for several days (for mild to moderate cases) or several weeks (for severe cases). Severe pancreatitis has a mortality rate of 20%.
- Infection of the bile duct (Cholangitis). This will require a hospital stay.
- Sometimes it is necessary for the doctor to cut a band of muscle (Sphincterotomy). During this procedure there is a 1% chance of perforation of the bowel wall or bile duct. If this should occur, it will require a hospital stay and sometimes requires surgery.
- Bleeding (1%). This is usually easily controlled during the ERCP. Occasionally bleeding can be severe and may require a blood transfusion. In rare cases, surgery may be required to fix the bleeding.
- Allergic reaction to the anaesthetic drugs.
- Allergic reaction to the contrast. These are extremely rare (less than 1%). They are usually controlled with medication administered as soon as the allergic reaction occurs.
- The mortality rate from an ERCP is 1-2:1000 (0.1-0.2%).

You will be nil by mouth for 2 hours after your procedure so we are able to monitor and assess you for signs and symptoms of pancreatitis. Depending on what procedure you have, you may be also be administered voltaren (rectally). This is used to reduce the risk of pancreatitis.

EUS

EUS (Endoscopic Ultrasound) is a procedure where a flexible scope with an ultrasound transducer on the tip is inserted via the mouth, down the oesophagus, through the stomach and into the upper part of the small bowel. This procedure allows your doctor to obtain images and information about your digestive tract and the surrounding tissue and organs. The images are passed from the scope and ultrasound transducer onto a screen where your doctor can view these areas.

In some patients, an EUS can be used to assist in obtaining a biopsy of a lump or lesion. This is performed with a thin needle and is called an FNA (fine needle aspiration) or FNB (fine needle biopsy). This helps the doctor determine the treatment you require. An FNA can also be used to drain fluid from a cyst.

As with all medical procedures, there are some risks of complication.

The complications involved with EUS are:

- Minimal risk of significant bleeding from an aspirate or biopsy site (~1%)
- Sore throat from the scope.
- Allergic reaction to the anaesthetic drugs.
- Pancreatitis (~1%)

Coeliac plexus block

Coeliac plexus neurolysis or block may be performed to provide relief from chronic pain associated with chronic pancreatitis or pancreatic cancer.

A mixture of dehydrated alcohol and local anaesthetic will be injected through a fine needle, under ultrasound guidance, into the coeliac plexus.

The complications involved with Coeliac plexus block are:

- Diarrhoea (5%)
- Pain (1%)
- Spinal cord injury (Very Rare)

General Information

- On arrival for the above procedure, you may be asked to wait in the reception area.
- **PLEASE NOTE** the time given to you by your specialist's rooms is your admission time and is not the time of your actual procedure.
- The actual investigation will be done on a bed, where you will remain until you recover from the sedation.
- You **MUST NOT** drive for 18 hours after the procedure if you have sedation and 24 hours after the procedure if you have a general anaesthetic. It is important that you arrange for someone to drive you home following your procedure and have a responsible adult stay with you overnight. (You are not permitted by law, to drive yourself).
- Please continue your usual medications unless discussed with your specialist.

I (full name) .....

agree that (procedure) .....
be performed on me (or full name of my child/relative/ward)

I have been able to discuss this with my specialist: ..... whose signature appears below. He/she has explained to me the reasons for and expected risks of the procedure relating to my clinical history and condition. I have had adequate opportunity to ask questions and have received all the information I want and I agree to the procedure/treatment. I understand that I am welcome to ask for more information if I wish, and my consent may be withdrawn at any time.

Signed (patient/representative): ..... Date .....

Signed (specialist): ..... Date .....

General Privacy Statement

We collect your health information to provide you with appropriate care and to monitor quality.
We share this information with other health care providers and agencies involved in your care.
We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons.
You have the right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.
Our full Privacy Statement is available on our website or from the hospital reception.

Account Information

Statement to be signed by patient before surgery.

I understand and agree that:

- Unless my specialist has advised me otherwise, any hospital fee figure given to me is an estimate only. For example, a procedure may take a shorter or longer time to complete, or, you may require a longer stay in hospital than originally estimated. In most cases though your specialist will be able to provide you with a reasonably accurate estimate.
- I am responsible for the payment of all costs associated with my stay at Braemar Hospital (excluding those which are paid for by another organisation such as ACC, an insurance company, a district health board etc).
- If I am an ACC patient, I will be invoiced for costs not paid by ACC, such as telephone calls, room upgrades, extra meals etc.

Before the procedure

- I give permission for Braemar Hospital to check on my current credit status before (or after) my procedure.
- If I have no insurance cover or no prior approval from my insurance company, Braemar Hospital may reserve the right to insist that I pay an estimate of the cost of my procedure in advance. (Braemar Hospital recommends that you obtain prior approval from your insurance company).

Invoice and payment

Unless another organisation such as ACC or a district health board are paying the full amount, I will receive invoices from:

- Braemar Hospital, the specialist, the anaesthetist (where applicable), and any other services such as physiotherapy (where applicable).

If I have insurance cover for my procedure, I agree to promptly:

- Send the invoice to the insurance company.
- Pay for all of the cost of the procedure that is not paid by my insurance company.

If I do not have insurance cover:

- I will pay the account in full promptly on receipt of invoice.

Overdue accounts

- I agree that I have sufficient funds in place to meet the costs of my procedure at Braemar Hospital on the due date.

If I do not pay on the due date:

- I will pay the interest charged by Braemar Hospital on any amount unpaid after the due date.
- The interest rate will be 1% per month of the amount unpaid at the end of each month.
- Braemar Hospital may instruct their debt collector or solicitor to recover any amount unpaid after the due date.
- I will pay for all of the debt collection costs incurred by Braemar Hospital or their debt collector and/or legal costs on a solicitor/client basis

I, Patient ◯ Parent ◯ Caregiver ◯

.....

have read and accept the above terms.

Signature: .....

Date: .....

(to be signed at Braemar Hospital)

BRAEMAR HOSPITAL TO AFFIX
PATIENT EMAIL LABEL HERE

Please complete this section prior to admission

ALLERGY STICKER

Do you have any allergies? If **YES** please provide details below.

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Health Questionnaire - To be completed by patient

Have you ever had or do you have any of any of the following?

If yes, please provide details below

	Yes	No		Yes	No		Yes	No
Asthma / Bronchitis	○	○	Diabetes	○	○	Blood clotting disorders	○	○
Sleep Apnea	○	○	Glaucoma	○	○	Possibility of pregnancy	○	○
Hypertension (High BP)	○	○	Metalware/ Prothesis (joint) / Pacemaker	○	○	Have had a gastroscopy / colonoscopy before?	○	○
Infectious Diseases (ESBL, MRSA, TB, Hepatitis, HIV)	○	○	Heart Problem (heart valve / heart attack)	○	○	Other (radiotherapy / chemotherapy)	○	○
Epilepsy	○	○	Liver / Kidney disease	○	○	Can you walk a flight of stairs?	○	○

If you answered **YES** to any of the questions above, please provide details, including treatment.

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Have you had any illness/surgery in the past? If **YES**, please provide details.

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Current Medication

Current Medications (please list):

.....

Are you taking any blood thinning medication? Yes ○ No ○

☐ Warfarin ☐ Aspirin ☐ Dabigatran (Pradaxa) ☐ Other: .....

If Yes, when did you last take them?: ..... INR Result (if applicable): .....

Pre-Procedure Nursing Assessment - To be completed by admitting Nurse

Weight: ..... BP: ..... HR: ..... SaO_2: .....

Last Food: ..... Last Fluid: ..... BGL result (if applicable): .....

Coag-check result (if applicable): ..... Jaundice: Yes ☐ No ☐

Patient has: ☐ Own teeth ☐ Crowns and Caps ☐ Partial Plate ☐ Hearing Aids ☐ Full Dentures

IV cannula insertion: ☐ R) ACF ☐ L) ACF ☐ R) Hand ☐ L) Hand

Sign: ..... Time: .....

Have you taken your usual medication today?: Yes ☐ No ☐ Consent signed: Patient ☐ Specialist ☐

Patient to be collected by: ..... Phone: .....

Valuables sent home with family member? Yes ☐ No ☐ Follow up phone call? Yes ☐ No ☐

Valuables placed in bottom draw in treatment room? Yes ☐ No ☐ Phone number: .....

Nurse Name: ..... Signature: .....

PLEASE AFFIX PATIENT DETAILS LABEL HERE

TRACEABILITY STICKERS

TIME IN:	TIME OUT:

ENDOSCOPE NUMBER

Procedure

- ☐ Gastroscopy
- ☐ EUS
- ☐ FNA
- ☐ FNB
- ☐ Coeliac Plexus Block
- ☐ ERCP
- ☐ Sphincterotomy
- ☐ Stone extraction
- ☐ Stent insertion
- ☐ Stent removal

Allergy: ☐ Yes ☐ No

Mouthguard: ☐ Yes ☐ No

Medication Administered During Procedure

Drug	Dose	Time	Nurse Signature	Nurse Signature	Dr. Signature
Voltaren PR					
Omnipaque 300mg/20ml + N/Saline 0.9% 20mls					
Dehydrated alcohol 96% 5mls + Marcaine 0.5% 5mls					

Biopsies

Endoscopy Nursing Notes

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Abdominal Pressure: ☐ Yes ☐ No Name: ..... Time Required: .....

Restart anti-coagulant medication - Date: ..... Sign: .....

Recovery Record

Arrival Time
Hrs

On Admission
- Unconscious
- Conscious at _____Hrs

Anaesthetic
- General
- Local
- Block
- Sedation
- No Sedation

Airway
- None
- Jaw Support
- Hudson Mask
- Optiflow
- NP
- Other

Resps
- Normal
- Shallow
- Low Rate

Time															
O^2															
SaO^2															
Resps															
220															
210															
200															
190															
180															
170															
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150															
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100															
90															
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70															
60															
50															
40															
30															
20															
10															

Recovery Room Discharge Comments

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IV Luer: ..... IV Fluids: .....

Nurse's Signature: ..... Discharge Time: ..... hrs.

Ward Medication

Date	Medication	Dose	Route	Freq.	Dr. Signature	Nurse Signature	Nurse Signature	Time

Ward Observations

Ward Nursing Notes

Time of Discharge: Signature:

Discharge Checklist

- Tolerating Fluids/light diet
- Pain controlled
- Post-procedure instructions given
- Copy of Endoscopy report given
- Referral Form sent/ copy to patient
- Prescription (if applicable)
- Valuables returned to patient (if applicable)
- IV cannula removed

Follow up phone call

Time of Discharge: Signature:

Sample Initials – Administrators/Other

Name (Printed):	REG No.	Initials	Name (Printed):	REG No.	Initials