Intermountain®
Avenues Specialty Clinic
324 E 10th Ave Suite 200
Salt Lake City, UT 84103
801.408.8399
801.408.5152 (fax)

Gastroenterology
Darcie Gorman, MD
Melvin Kuwahara, MD
Joseph T. Merrill, MD
Dan A. Collins, MD

ERCP
(Endoscopic Retrograde Cholangiopancreatograpy)

Thank you for choosing us to perform your procedure. Please carefully read the following packet of information. If you have questions, please contact our office at (801) 408-7500, option 3 and ask to speak to our nurse, or your doctor's medical assistant. If you need to cancel or reschedule we require a 48hrs notice.

Your procedure is scheduled on _____ ____at_____ with Dr. Darcie Gorman, Dr. Melvin Kuwahara, Dr. Joseph Merrill, or Dr. Dan Collins

Please arrive at LDS Hospital at _____ for check-in. You need to check in ONE HOUR before your procedure time.

Endoscopic Retrograde Cholangiopancreatograpy (ERCP) is used to diagnose problems in the liver, gallbladder, bile ducts and pancreas. ERCP is used primarily to diagnose and treat conditions of the bile ducts, including gallstones, inflammatory strictures (scars), leaks (from trauma and surgery), and cancer.

ERCP combines the use of x-ray and endoscope (which is a long, flexible lighted tube). Through the endoscope your physician can inject dye into the bile ducts and pancreatic duct so they can be seen on X-rays. Using special equipment he can remove stones or "sludge" and take biopsies. A stent may be placed if there is a stricture or blockage (sludge) in the duct. A small brush may be used to obtain samples as well. Strictures may also be dilated with special balloons, if needed. A "spy glass", a very small camera that is able to go inside the ducts for direct visualization, as well as obtaining biopsies, may be used during your procedure.

How long will the procedure take?

- An ERCP can take anywhere from 30 minutes to 2 hours depending on what is found during the scope.

What preparation is needed for an ERCP?

- You must have NOTHING to eat or drink for 8hrs prior to procedure.

Will my insurance company pay for my Upper Endoscopy?

- Please call your insurance company prior to your procedure to see what portion of the procedure you may be financially responsible for. Any charges not covered by your insurance will be your responsibility.

Medication Precautions

- Blood thinning medications need to be adjusted prior to your procedure, please call the nurse at the office to discuss. Antibiotics are not usually required prior to your procedure unless you procedure is going to include laser lithotripsy (breaking up stones into smaller pieces).

What are the risks of an ERCP?

- Perforation, which is where the scope would make a hole in the esophagus, stomach or duodenum. This requires immediate surgery and may cause a systemic infection, organ failure, and could potentially lead to a fatal outcome.
- Side effects of the sedation medication can include decreased respirations and heart arrhythmias.
- Infection or bleeding if tissue samples are taken.
- Pancreatitis, which is a painful condition that may require hospitalization and treatment for other conditions related to pancreatitis.

TODAY'S DATE . / / .

PATIENT NAME: ☐ M ☐ F	PREFERRED NAME:	PHONE # H W C	AGE/ DOB
REASON FOR ADMISSION / NAME OF PROCEDURE	PROCEDURE DATE	SURGEON / DOCTOR	PRIMARY CARE PHYSICIAN ☐ NONE

ALLERGIES/ REACTION ☐ NONE ☐ MEDICATIONS ☐ FOODS ☐ LATEX ☐ TAPE ☐ OTHER — LIST ITEM & REACTION — HT. — WT.

PREVIOUS HOSPITALIZATION(S) OR OPERATIONS
(INDICATE APPROXIMATE YEAR)

HAVE YOU HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

(Malignant Hyperthermia, Dark Colored Urine, Unexplained High Fever, Muscle Weakness after Procedure, Complications)

HEALTH HISTORY

YES	NO	Have You Ever Had:
		Diabetes Controlled by: ☐ Diet ☐ Pills ☐ Insulin
		Hypoglycemia (Low Blood Sugar)
		Thyroid Problems
		Heart Problems (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, Angina, Ankle Swelling, Valve Replacement, Pacemaker, Heart Failure, etc.)
		Blood Clots, Transfusion Problems, Or Bleeding Tendency (Hemophilia, Anemia, Sickle Cell Anemia, etc.)
		High Blood Pressure
		Stroke (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)
		Seizures (Epilepsy, Convulsions, Blackouts, etc.)
		Neurological Problems (Loss of Sensation, Numbness, Tingling, etc.)
		Severe Headaches
		Glaucoma (Have you ever had or are you receiving treatment for)
		Lung Problems (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, Oxygen, Tracheostomy, Ventilator, etc.)
		Tuberculosis / TB
		Sleep Apnea (Breathing Interruption During Sleep, etc.)
		Liver Problems (Jaundice, Hepatitis, etc.)
		Kidney, Bladder Or Prostate Problems (Infections, etc.)
		Stomach Problems (Ulcer, Hiatal Hernia, Reflux, Heartburn, Nausea/Vomiting, etc.)
		Bowel Problems (Irritable Bowel, Diverticulosis, Diarrhea, etc.)
		Back Trouble (Strain, Disc Problems, Numbness/Tingling of Hands or Feet, etc.)
		Broken Bones Of Head, Neck Or Spine, Restrictions In Movement Or Difficulty Opening Mouth (TMJ, etc.)
		Arthritis
		Muscle Disorders (MD, Myasthenia Gravis, Myositis, MS, etc.)
		Cancer (History or current treatment)
		Mental Health / Phobias (Anxiety, Depression, Psychosis, etc.)
		Mental Disability (Confusion, Memory Loss, Downs Syndrome, etc.)
		Skin Problems (Eczema, Fragile, Skin Breakdown, etc.)
		Pain In The Past Several Weeks Or That Limits Daily Activity
		Chronic Infection (MRSA, VRSA, VRE, etc.)
		Other Medical Problems
		Nutrition Problems (Eating Disorders, Special Diet, TPN, etc.)
		Any Recent Illness, Cold, Cough or Fever? (Pneumonia, Flu, RSV, Strep)
		Recent Exposure To Any Communicable Diseases?
		☐ Influenza Vaccine (Last 12 Mo) ☐ Pneumonia Vaccine

ADVANCE DIRECTIVES

YES	NO	Do you have any of the following types of advance directives? (If you mark YES to any, we need a copy to honor your wishes.)
		A Physician's Order (POLST, Life with Dignity Order, POST or an order from another state)
		An Advance Health Care Directive
		A Living Will
		A Durable Power of Attorney for Healthcare
		A Medical Treatment Plan
		If YES to any, was a copy requested?
		If YES to any, does this document still reflect your/patient's wishes?
		Would you like more information or assistance? ☐ Info Given

YES	NO	
		Do You Currently Use Or Have A History Of Using Tobacco? No. Of Yrs Used Packs/Day Date Quit
		Tobacco Cessation Booklet ☐ Given ☐ Declined
		Does Anyone In Your Household Smoke?
		Do You Drink Alcoholic Beverages? How Often How Much
		Do You Have A History Of Substance Abuse Or Addiction?
		Do You Have Any Of The Following: ☐ False Teeth ☐ Chipped Teeth ☐ Braces ☐ Bridges ☐ Contact Lenses ☐ Loose Teeth ☐ Caps/Crowns ☐ Retainers ☐ Body Piercing ☐ Hearing Aids
		Do you have any special needs / concerns? ☐ Vision _____ ☐ Hearing _____ ☐ Speech _____ ☐ Language _____ ☐ Translator Requested ☐ Learning Needs _____ ☐ Physical Limitations _____ ☐ Environmental Concerns (room temperature, lighting, etc.) _____ ☐ _____
		Do You Currently Need Assistance To Get Around The House, Do Errands, And Take Care Of Your Personal Needs?
		Would You Like To Discuss Any Concerns, Fears Or Special Requests?
		Do you use any of the following? ☐ Oxygen ☐ CPAP ☐ BiPAP ☐ Other _____
		Do you have any problems sleeping? ☐ Breathing difficulties ☐ Snoring ☐ Pain ☐ Insomnia ☐ Need sleep aids ☐ Up at night to use bathroom ☐ Do not feel refreshed upon waking ☐ Have been told breathing has stopped for short periods of time while sleeping
		Women: Is There A Possibility You Are Pregnant? Last Menstrual Period:
		Women: Are You Breastfeeding?

YES	NO	IF THE PATIENT IS A CHILD: (17 & under)
		Was The Child Premature? Gestational Age:
		Any Birth Defects Or Developmental Problems?
		Any Immunization Problems Or Delays?
		Any History Of Breath Holding, Breathing Problems, Croup or BPD? RSV-Date Resolved

THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.

X _____ _____ _____
PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE — RELATIONSHIP — DATE

Hospital / Agency Interpreter name _____

Patient/parent declined hospital / agency interpreter (patient/parent has been advised that interpretation is free) and request made by the patient/parent to use (name) _____ (relationship) _____

☐ Medication History Completed and Reviewed

Reviewed by _____ **RN Date** _____ **Time** _____

PATIENT HISTORY

Complete form within 24 hours of admission (see instructions on back of form)

☐ Source of Medication List: _____ ☐ NO HOME MEDICATIONS ☐ Unable to obtain medication history [give reason and follow-up plan (i.e. family bringing in)]:	☐ NO KNOWN ALLERGIES ALLERGIES (medications, food, vaccines, latex, dyes, etc.): DESCRIBE REACTION or ALLERGY:
Primary Care Physician:	
Patient's Home Pharmacy:	

CURRENT MEDICATIONS ON ADMISSION

Include all prescriptions, over-the-counter medications, patches, inhalers, vitamins, teas, herbal, dietary, supplements

Medication [Include dosage form if indicated (EC, XL, SR, etc.)]	Dose (amount)	Route (oral, topical, inject, etc.)	Frequency (how often taken, if taken regularly or only when needed)	ADMIT ONLY When Last Taken: Date	Time	DISCHARGE ONLY When Next Dose Due: Date	Time

Med Hist 50225

History obtained/reviewed by: Date: Time:

History obtained/reviewed by: Date: Time:

NEW MEDICATIONS TO BE CONTINUED AT HOME

COMPLETE LIST INCLUDES YOUR CURRENT MEDICATIONS ABOVE AND NEW MEDICATIONS ADDED BELOW

Medication	Dose	Route	Frequency	HOME SCHEDULE MORNING	NOON	EVENING	BEDTIME	Crossed-out drugs on list should not be taken until you check with your Ordering Physician	Next Dose Due: Date	Time

LIP/RN Signature: _____ Date: _____ Time: _____

LIP/RN Signature: _____ Date: _____ Time: _____

Patient given a copy and instructed to keep a complete list of medications with them and to give to other healthcare provide

Stamp plate or Patient Name

Intermountain Healthcare

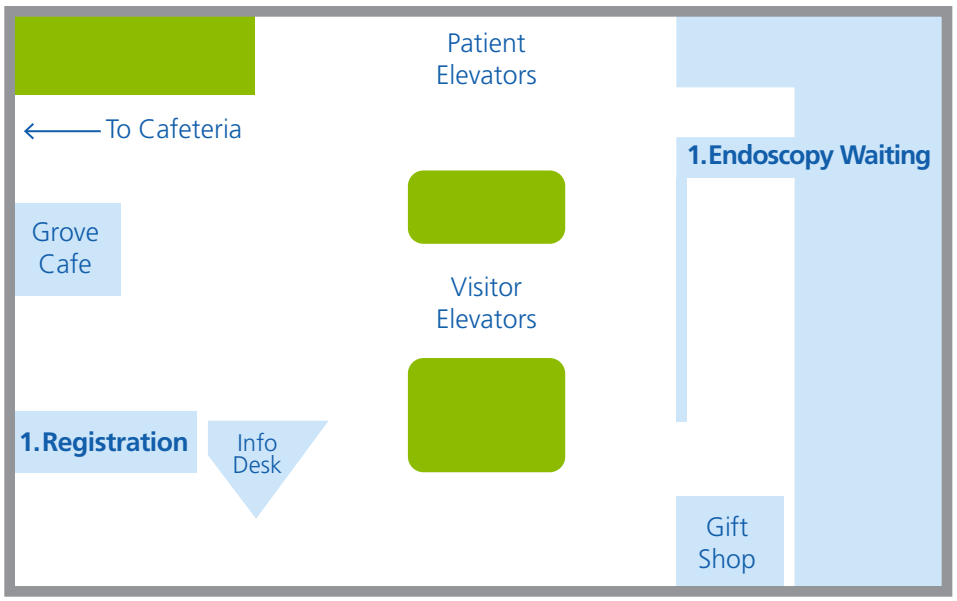
Medication History and Discharge Form

White: Medical Record Yellow: Patient Pink: Pharmacy


AVENUES SURGICAL CENTER
EMERGENCY ROOM
Enter On East Side L1
South Temple
CENTRAL TOWER
Access through main entrance
Pulmonary C6
Sleep Services. C5
NORTH ENTRANCE /NORTH WING
Infusion. N3
Behavioral Health . . . N5 & N6
Radiation Therapy N1
E Street
8th Avenue
D Street
7th Avenue
MEDICAL OFFICES
HUNTSMAN EDUCATION CENTER
PHYSICIAN OFFICE BUILDING
UTA STOP
UTA STOP
9th Avenue
C Street
8th Avenue
Patient Parking
Valet Service
6 a.m. to 2 p.m.
FREE (No tipping please)
Intermountain℠
LDS Hospital
8th Avenue and C Street
SLC, Utah 84143 • 801-408-1100
MAIN ENTRANCE / MAIN PATIENT TOWER
Bone Marrow Transplant . . . E8
EKG, Echo E7
Peripheral Vascular E7
Intensive Care Unit E6
Wound Care. E6
Hyperbaric Medicine E6
Same Day Surgery W3
Surgical Unit W6
Orthopedic Unit. W7
Joint Center W7
Medical, Surgical Unit W8
Maternal Fetal Medicine . . . 4th
Labor & Delivery 4th
Maternity 4th
Emergency Department. . . . 1st
Endoscopy. 1st
Imaging Registration 1st
MRI, CT, Mammography, Ultrasound, Angiography, Nuclear Medicine 1st
NORTH

LDS HOSPITAL ENDOSCOPY

1. Check in at Registration
2. Check in at Endoscopy waiting area with receptionist



C STREET - MAIN ENTRANCE

PATIENT PARKING