Massachusetts General Hospital Interventional Endoscopy

Thank you for allowing us to participate in your care!

Procedure Information

Scheduled Procedure: _____

Patient Name: _____

Date: _____

You have a _____ procedure. Please arrive at _____

Location: MGH Endoscopy Unit, 4th Floor of the Blake Building

Physician and Phone Number: _____

*It is very important that you keep this appointment. If you must cancel, please do so at least **5 business days in advance**. If you have any questions or concerns, please contact us.*

Important Pre-Procedure Information

What to Bring to Your Exam

**** Please refer to the day of procedure instructions attached with your prep for important covid pre-procedural related inquiries.***

- ☐ For your safety, please arrange for an adult escort to take you home following your procedure. **You will not be permitted to drive or arrange ride share/taxi services. If you do not have an adult escort, hospital policy requires us to cancel and reschedule your procedure.**
- ☐ Name and phone number of your escort if they cannot be with you when you check in. They should be available to pick you up within 30 minutes of being called.
- ☐ A SAMPLE copy of the **MGH Patient Consent to Procedure form** (see last page) is included in this packet for your review. If you are unable to consent on the day of your exam, a signed Health Care Proxy Form must be provided or your Proxy must be present to state consent on your behalf. Your Proxy can also state consent over the phone by calling our office within 30 days of the exam. **If consent is not provided, hospital policy requires us to cancel and reschedule your procedure.**
- ☐ Please note that MGH policy requires that women, ages 11-55 years old have a pregnancy test prior to having any endoscopic procedure. When you arrive for your procedure, a registered nurse will screen you for the test and if needed, request that you provide a urine sample.
- ☐ Photo identification
- ☐ Updated medication list
- ☐ Do not wear jewelry other than wedding rings.

Medications

- ☐ If you have diabetes, contact your prescribing doctor about the suggested changes below

Stop 4 days before	☐ Etugliflozin (Steglarto, Steguian, Segluromet)
Stop 3 days before	☐ Canagliflozin (Invokana) ☐ Canagliflozin AND Metformin (Invokamet) ☐ Dapagliflozin (Farxiga) ☐ Dapagliflozin AND Metformin Extended-Release (Xigduo XR) ☐ Empagliflozin (Jardiance)
Day of procedure	☐ If you take insulin, only take 1/2 dose

☐ **If you take blood thinners** (Coumadin, Plavix, Pradaxa, Lovenox, etc.) we recommend you continue unless you have specifically been asked to stop by the GI physician performing your exam. **Please contact your cardiologist or prescribing physician to confirm blood thinner instructions.**

Procedure Preparation Instructions

Day of Your Procedure

- ☐ If you have a **MORNING** procedure, do not eat or drink anything after midnight on the night before the procedure.
- ☐ **If you have an AFTERNOON procedure, you may have a clear liquid breakfast.** Clear liquids include water, tea, black coffee, apple juice, Gatorade, and soda. **Jell-O and Broth are not considered clear liquids.** If you have Jell-O or broth the day of your procedure, it will be canceled. Do not add milk products to beverages. **Stop clear liquids 4 hours before your procedure.**
- ☐ Do not have gum or hard candy within 4 hours of your procedure.
- ☐ Take all of your usual medications including medications for high blood pressure with small sips of water.

After Your Procedure

- ☐ You will be monitored in the Endoscopy Unit Recovery Area for approximately 1 hour.
- ☐ Please bring personal items in case you are admitted to the hospital after the procedure.
- ☐ You will receive diet and medication instructions.
- ☐ You may return to work the day after the procedure.

Please note, we are an Endoscopy Unit facilitating both outpatient and inpatient needs.
Due to the nature of the complex procedures we perform, unavoidable delays may occur.
Please plan accordingly. Every effort is made to start your procedure on time.
We appreciate your patience and flexibility!

Directions from Parking to Endoscopy Unit

We are located on the 4th Floor of the Blake Building
55 Fruit Street, Boston, MA 02114

From the Fruit Street Garage or Parkman Street Garage:

1. After parking, enter through the MGH main entrance
2. Take the E elevator to the 4th floor of the Blake Building
3. Once you exit the elevator, looks for the glass door labeled MGH GI Associates

For driving directions and more information, please visit the Parking and Visitor Information website
www.massgeneral.org/visit
For more information and frequently asked questions, please visit our website
www.massgeneral.org/medicine/gastroenterology/about/frequently-asked-questions

This document was reviewed by the staff of the Blum Center for plain language.

Mass General Brigham

Hospital: Massachusetts General Hospital

Patient Identification Area

PATIENT MUST BE IDENTIFIED BY:

NAME: _____

DOB: _____ (MM/DD/YY)

MEDICAL RECORD NUMBER: _____

CONSENT FOR PROCEDURE

I allow _____ to perform the procedure

Endoscopic Retrograde Cholangio-Pancreatography (ERCP)

Operative Site: _____

If laterality applies: ☐ Right ☐ Left ☐ Both Sides ☒ NA

I have been told the risks and benefits of the procedure. I also know that there are other choices. I understand the risks and benefits of these other choices. I understand what could happen if I do not have the procedure.

I understand that medicine and surgery are not exact. I understand there are no guarantees for the outcome of this procedure.

I understand that loss of blood, infection, or pain may happen with any procedure.

My care team explained the risks below:

ERCP is an important test for the evaluation of pancreatic and biliary disorders. The test will be performed to examine the bile and pancreatic ducts with contrast dye and x-ray. If a gallstone is found, it will be removed. If there is a blockage of a duct, a stent will be placed in the bile or pancreatic ducts. There are risks associated with this procedure and they include pancreatitis, bleeding, pain, and infection. Pancreatitis and perforation are rare complications but may be serious and require hospitalization, blood transfusion, or surgery. There is potential for bruising or soreness in the mouth. In rare instances, teeth may be dislodged or damaged.

Sometimes patients need to be put to sleep for a procedure. This is called sedation. My doctor discussed the risks of sedation. These risks include slower breathing and low blood pressure. If these happen, I might need treatment. I understand there may also be other risks.

I understand that I might lose blood during the procedure. If that happens, I may need blood products. This could be during or after the procedure. If I do not want blood products, I will fill out a separate form.

I understand that other people may be in the room during my procedure. This includes observers or people who work for medical equipment and device companies. They will be observing or giving advice.

The hospital may take photos or recordings of my procedure. These photos or recordings will be used for education, research, and other healthcare operations. My identity will not be revealed when these are used.

The hospital may throw away blood or other samples taken from me during the procedure. The hospital or its partners may also use the samples. They may be used for activities that support research, education, or other parts of the hospital's mission.

Mass General Brigham

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Patient Identification Area

PATIENT MUST BE IDENTIFIED BY:

NAME: _____

DOB: _____ (MM/DD/YY)

MEDICAL RECORD NUMBER: _____

CONSENT FOR PROCEDURE

A team will work together to do my procedure. My doctor told me about the senior attending and others who might help. The team might have doctors, advanced practice providers, or students. I know that other people besides the senior attending might do parts of the procedure. This includes but is not limited to:

- Opening or closing the surgery spot.
- Collecting grafts.
- Removing or moving tissue.
- Doing exams like breast, pelvic, prostate, or rectal exams, if needed.

The roles and names of other people in the procedure are listed below. I know that other medical staff not listed might also be part of my surgery. I will learn their names later.

Role of Practitioner (check all that apply)		Name of Practitioner if known
	Fellow.	
	Resident. Specify Year:	
	Physician Assistant	
	Advanced Practice Nurse	
	Other, please specify:	
	Other, please specify:	

☐ My doctor has told me that my procedure will overlap with another procedure they are doing. I understand that my doctor will be in the operating room during the most important parts of my procedure. I understand that they may not be there for the whole procedure. I understand that my doctor or another qualified doctor will be available immediately, if needed, during my procedure.

I had a chance to ask questions about the risks, benefits, and side effects of the procedure. I was also able to ask questions about the chances of achieving the goals of the procedure and other options. All my questions were answered. I agree to the procedure.

_____	_____	_____	AM PM
Patient/Legal Surrogate Decision Maker Signature	Printed Name	Date	Time
_____	_____	_____	AM PM
Practitioner Obtaining Consent Signature	Printed Name	Date	Time

Attending Physician/Primary Practitioner Attestation

I confirm that I explained all relevant parts of this procedure. This includes the indications, risks, and benefits. I compared other approaches with the patient or legal surrogate decision maker. I answered their questions. I provided information about other medical professionals who will be present during the surgery.

_____	_____	_____	AM PM
Attending/Practitioner Signature	Printed Name	Date	Time

If interpreter was used provide name or number of interpreter: _____

Telephone/Verbal Consent (applicable if the patient is incapacitated)

Date: _____ Time: _____ AM PM Reason for Telephone/Verbal Consent: _____

Legal Surrogate Decision Maker Name: _____

Consent Received by: _____

Consent Witnessed by: _____