Affix Patient Label

Patient Name: _____ Date of Birth: _____

This information is given to you so that you can make an informed decision about having **carpal tunnel surgery**.

Reason and Purpose of the Procedure:

You have carpal tunnel surgery done to treat numbness and pain in your wrist. The numbness and pain is caused by your compressed median nerve. The surgery is done by cutting a ligament in your wrist to take the pressure off the nerve. This ligament will become a little bit longer when it heals. The goal of carpal tunnel surgery is to:

- Lessen pain and numbness.
- Keep you from getting nerve damage.
- Improve grip.
- Decrease dropping of objects.

Benefits of this surgery:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Reduce pain.
- Help with numbness.
- Better strength.
- Decrease dropping of objects.

Risks of Surgery:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of surgery:

- Small areas of the lungs may collapse. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- A strain on the heart or a stroke may happen.
- Bleeding may happen. If there is a lot of bleeding, you may need more surgery.
- You may have a reaction to the anesthetic. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesia provider will discuss this with you.

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Risks of this surgery:

- **Infections are rare, but serious when they happen**. If you get an infection you may need more surgery and antibiotics.
- **The carpal tunnel can again become tight**. You may have pain and numbness again.
- **Scarring around your tendons**. This can limit motion of fingers and thumb.
- **Damage to nerves, tendons, and artery structures during the surgery**. If this happens you may need further repair.
- **The surgery may not make your symptoms better**. Nerves may be compressed at the other body sites in addition to the carpal tunnel.

Risks associated with smoking:

Smoking is linked to an increased risk of infections and delayed healing. Both can be serious complications.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with diabetes:

Diabetes can increase the risk of infection and slow wound healing.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

- Do nothing. You may decide not to have the procedure.
- Pain management (medications)
- Steroid injections
- Change your activities (avoid activities that make your pain or other symptoms worse)
- Carpal tunnel braces

If you choose not to have this treatment:

- Your doctor can discuss the alternative treatments with you.

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General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure the doctor may need to do more tests or treatment.

I understand that in the event of an emergency my doctor may ask a partner to do the surgery.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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Patient Name: _____ Date of Birth: _____

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: _____ **carpal tunnel release**.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

Patient Signature _____ Date _____ Time _____

Relationship ☐ Patient ☐ Closest relative (relationship) ☐ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

_____ _____ _____

Interpreter (if applicable) *Date* *Time*

For provider use only:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options and possibility of complications and side effects of the intended intervention. I have answered questions and patient has agreed to procedure.

Provider Signature:_____Date:_____Time:_____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

or

____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness:_____Date:_____Time:_____