



**CONSENT FORM  
FOR  
CARPAL TUNNEL RELEASE**

Med Rec. No. ....

Surname: .....

Forename: .....

DOB: .....

AFFIX LABEL HERE

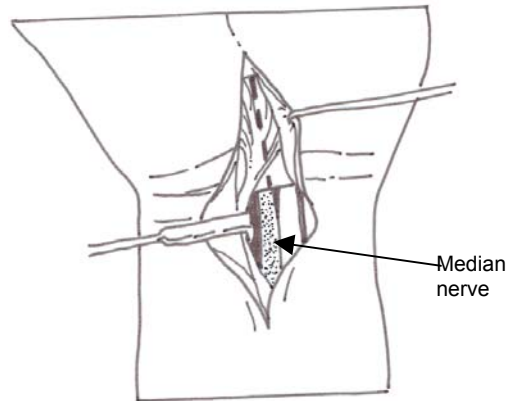
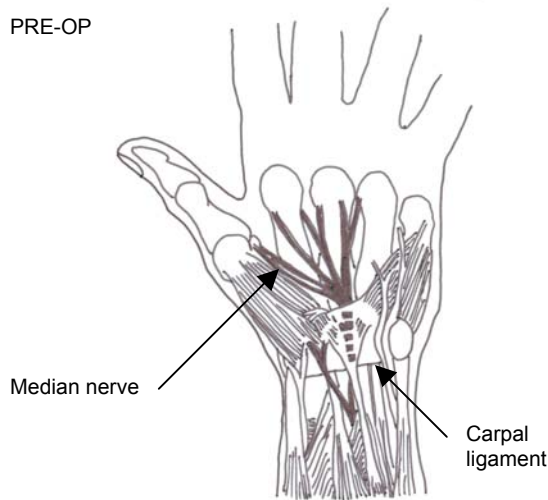
**PROPOSED TREATMENT**

The doctor has explained that I, (*name of patient*) ....., have **carpal tunnel syndrome** and that a **carpal tunnel release operation** is proposed on the .....side:

**This means an operation to decompress a tight tunnel between the wrist and the hand, which otherwise may cause pressure damage to one of the main nerves to the hand (median nerve). A general or regional anaesthetic is used with a tourniquet to the arm during the procedure to limit bleeding in the operation site and allow the surgeon a clear view.**

**A cut is made on the inner surface of the wrist/hand and deepened until the tight ligament forming the roof of the carpal tunnel is seen. This ligament is carefully cut, protecting the median nerve, which lies immediately underneath. Once the nerve is completely free, the skin only is closed with stitches and the hand dressed with a thick wool and crepe bandage and kept elevated in a sling for some hours to limit swelling and bleeding.**

PRE-OP



OPERATION IN PROGRESS

**RISKS**

*The following risks are those that may most commonly occur. There may be other unusual risks that have not been listed here. Please ask your surgeon if you have any concerns.*

I understand there are risks associated with any anaesthetic (*see separate Anaesthetic Consent Form*). I understand that I may have side effects from any of the drugs used. The most common side effects include headache, light-headedness, constipation and rash.

I understand the procedure has the following **specific risks and limitations**:

- I may develop a wound infection, with swelling and redness. This may require antibiotics
- If my median nerve is inadvertently damaged during the operation, I may notice:
  - Loss of sensation to the index finger and thumb
  - Weakness of small muscles that move the thumb
- I will have a scar where the cut was made and in some cases, this may remain painful for some time.
- Rarely, I may have a blood clot in the wound that may need to be cleared out.
- Rarely, I may develop a condition called reflex sympathetic dystrophy (pain, swelling and change in temperature and colour of the hand). If this happens, I should tell my doctors immediately as early treatment may help reduce symptoms.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

RISKS CONTINUED OVERLEAF →

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**INDIVIDUAL RISKS**

I have discussed the following **risks with the surgeon as these have influenced my decision** to have this operation:

**DECLARATION BY PATIENT**

- I acknowledge the neurosurgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my surgeon during this operation.
- I understand that a doctor other than the specialist may perform the procedure.
- I understand that no guarantee has been given to me that this operation will be successful.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I have received a copy of this form to take home with me.
- If a needlestick/sharps injury occurs to staff during any operation I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the operation if this has been necessary.

**Signature of patient**

**Date:**

*If the patient is an adult and unable to give consent, a proxy form must be completed and attached*

**DECLARATION BY DOCTOR**

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

**Doctor's Signature**

**Doctor's name**  
*(please print)*

**Date**

**INTERPRETER'S DECLARATION** - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

**Interpreter's signature**

**Date**

**Interpreter's name**  
*(please print)*