מס' זהות:

שם משפחה: שם פרטי:

שם האב: תאריך לידה:

כתובת:

טלפון: **מדבקת פרטי מטופל**

טופס הסכמה: ניתוח לשחרור העצב המדיאני/אולנרי בתעלת שורש כף היד

Consent Form: Release of Carpal Tunnel Syndrome (CTS)

Release of Ulnar Nerve – Guyon's Canal

The purpose of the operation is to relieve the patient of the pain that occurs as a result of pressure on the median/ulnar nerve in the wrist. The cause of pressure is usually unknown. In a minority of cases, a tumor or anatomical change is found to be responsible for the pressure. In some cases, there is evidence of a previous injury.

The operation involves cutting an incision in the skin above the wrist, releasing the subcutaneous tissues and cutting through the ligament that is exerting pressure on the nerve. If additional findings are discovered during surgery, such as proliferation of the tissue surrounding the tendons or scarring around the nerve, the surgeon will remove the proliferating tissue and release the nerve from the scars.

The incision is closed with sutures that are removed after 7 to 14 days. The operation is performed under local and/or regional anesthesia, combined with a tourniquet installed on the operated arm. The tourniquet may cause a sensation of pressure on the arm.

Name of Patient: _______________ _______________ _______________ _______________
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _______________ _______________
Last Name First Name
regarding the need for an operation to relieve the **median / ulnar** * nerve in the **right / left** * carpal tunnel (henceforth: "the primary operation").

I have been given an explanation concerning the expected results of the operation and the possibility of slow recovery of the nerve. In a minority of the cases, recovery is associated with the side effects mentioned below and may be prolonged. At times the syndrome may recur and its repair will require repeat surgery.

I hereby declare and confirm that I have been given an explanation concerning the side effects following the primary operation, including: pain, discomfort, swelling of the hand and fingers, limitation of motion and subcutaneous hemorrhages that are spontaneously absorbed.

In addition, I have been given an explanation concerning the possible risks and complications, including: hemorrhage and infection that will require treatment.

I hereby give my consent to perform the primary operation.

In addition, I hereby declare and confirm that I have been given an explanation and understand the possibility that during the primary operation the need to extend or modify the operation or to perform additional or different procedures may arise in order to save my life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time but whose significance has been made clear to me. I, therefore, also give my consent to such an extension,

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modification or performance of different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary operation.

I hereby also give my consent to the administration of local and/or regional anesthesia combined with the use of a tourniquet, after having been given an explanation concerning the risks and complications of the local anesthesia, including various degrees of allergic reactions to the anesthetic drug and the possibility of neural and/or vascular damage with regional anesthesia.

If the need arises to perform the primary operation under general anesthesia, I will receive an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the operation and any other procedure will be performed by any designated surgeon, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

________________	________________	________________
Date	Time	Patient Signature

________________	________________
Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

________________	________________	________________
Name of Physician	Physician Signature	License No.

* Cross out irrelevant option.