



Personal Decision Guide

Carpal Tunnel Syndrome



Use this guide to talk with your doctor or support person



to help you make a decision.

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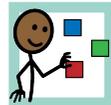
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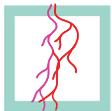
SECTION 1



What is Carpal Tunnel Syndrome?

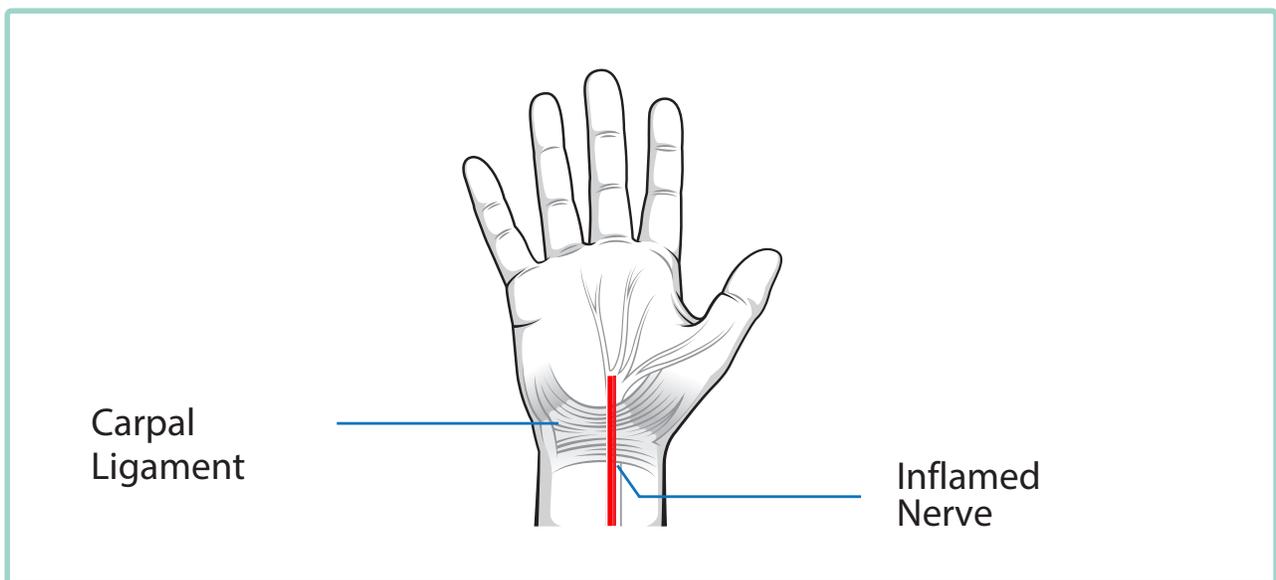


Carpal tunnel syndrome is caused by swelling and pressure on



a nerve in the wrist. Repeated hand and wrist movements may cause this.

Carpal Tunnel Syndrome: Inside Your Wrist





You may have:



Pain.



Weak thumb and finger muscles.



Loss of feeling.



Difficulty using your fingers and hand.



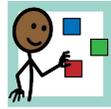
Tingling or numbness in your fingers and hand.



Personal Decision Guide

Carpal Tunnel Syndrome

SECTION 2



Treatment Choices



A. Non-Surgery



B. Surgery



A. Non-Surgery Treatment: 7 Options



1-2



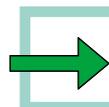
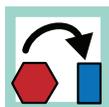
1) Rest your hand 1 to 2 weeks by using it a lot less.



10-15



2) Put an ice pack on your palm and wrist for 10 to 15 minutes at a time.



3) Change the way you do some hand movements.

Personal Decision Guide



4) Ask your doctor about taking medicine called non-steroid anti-inflammatory drugs (NSAIDs)



Read the label for instructions and any side effects.



5) Wear a wrist splint.



6) Work with an Occupational or Physical Therapist.



7) Ask your doctor about corticosteroid shots or pills.

Non-Surgery Treatment: Benefits and Risks



Benefits



• No surgery risks or costs.



• Could be all you need to get better.



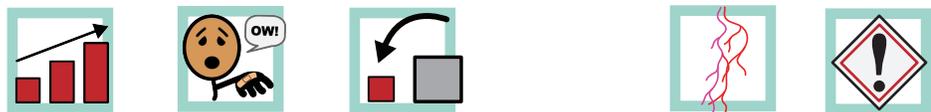
Risks



• Bad symptoms over time could cause nerve damage that



never gets better.

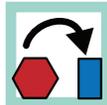


• Temporary increase in pain, or a small chance of nerve damage,



after a corticosteroid shot.

Non-Surgery Treatment: What Have You Tried?

Treatment	Tried	Can Not Try	Want To Try	Helped	Did Not Help
 Rest	<input type="checkbox"/>				
 Ice	<input type="checkbox"/>				
 Change ways to do tasks	<input type="checkbox"/>				
 NSAID medicine	<input type="checkbox"/>				
 Wrist splint	<input type="checkbox"/>				
 Occupational or Physical Therapy	<input type="checkbox"/>				
  Corticosteroid shot or pills	<input type="checkbox"/>				



B. Carpal Tunnel Surgery



Your doctor might recommend surgery if:



You've had very bad symptoms for a long time, so you're at



risk of having nerve damage that never gets better.

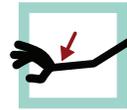
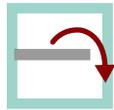


Tests show that you have nerve damage.



You have tried non-surgery treatments and they haven't helped.

Surgery: What is it?



Surgery takes the pressure off of a nerve in the wrist.



The doctor cuts a ligament to stop the pressure on the nerve.



The surgery is called Carpal Tunnel Release. There are 2 types:



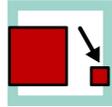
1. Endoscopic



2. Open



1. Endoscopic



or



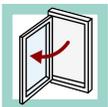
Your doctor makes one small cut in the wrist, or one small cut in the wrist



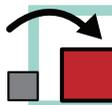
and one in the palm. They put a thin tube with a camera attached (endoscope)



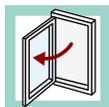
into the cut. Surgical tools are put in with the scope to cut the ligament.



2. Open

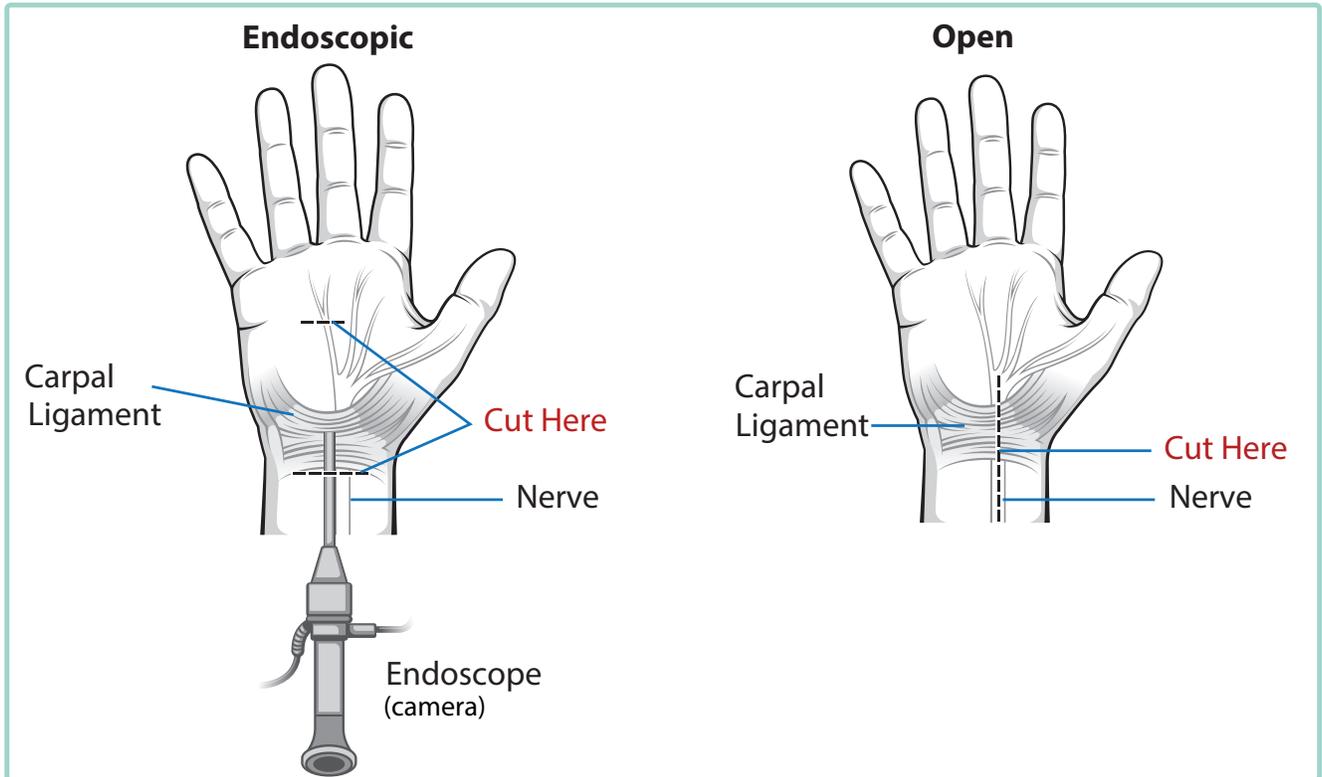


Your doctor makes a larger cut in the palm of your hand to cut

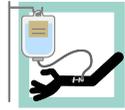


the ligament. Open surgery can take longer to heal than endoscopic.

Where the doctor cuts for surgery:



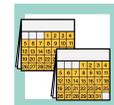
Surgery: What to Expect?



- You have local anesthetic, so you are awake but won't have pain.



- You go home on the same day.



- You must avoid heavy use of your hand for up to 3 months.



- Healing is usually faster with endoscopic surgery.



- You may return to regular activities within 2 - 8 weeks, depending on

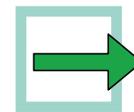


which hand had the surgery. Talk to your doctor about healing time.

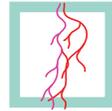
Surgery: Benefits and Risks



Benefits



- Surgery can make symptoms get better or go away.



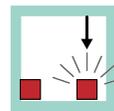
- It can prevent permanent nerve damage.



Risks



- Surgery doesn't always help. Your symptoms may come back.



- Infection or a problem from anesthesia is rare but can occur.



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Carpal Tunnel Syndrome

SECTION 3



Making a Decision



What's important to me (my values):



Do not agree



No opinion



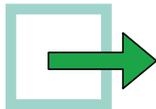
Agree



I am worried about problems from surgery.



I am worried about nerve damage that never gets better.



I want the pain to go away, no matter what.



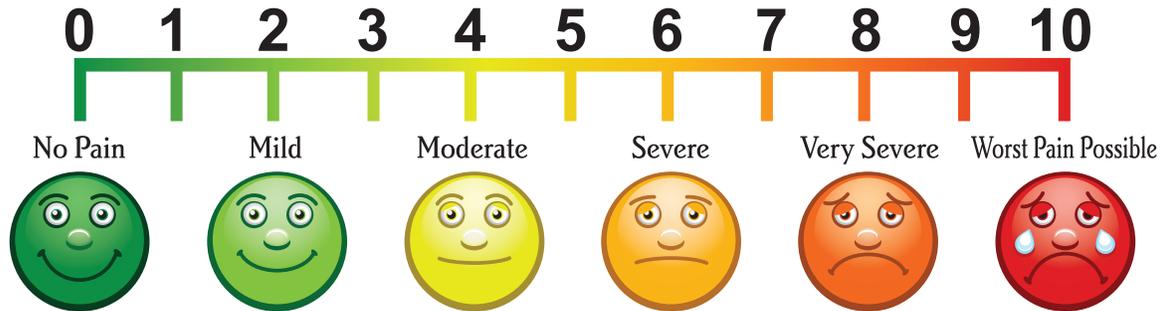
I want to try all the non-surgery options first.



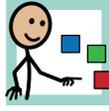
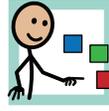
Other important things to me:

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Some people make a choice depending on how much pain they feel in their wrist. Circle your level of pain:



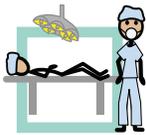
Do You Have What You Need to Make a Decision?

   <p>Do you understand your treatment options?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
    <p>Do you understand the risks and benefits of your options?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
   <p>Do you have the support you need to make a decision?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>

What is Your Decision ?



Non-Surgery Treatment



Surgery



I Don't Know (Undecided)

If you haven't decided, check any of these, if they apply:



I need more information



I want to talk about my choices with someone

(add name if you know it): _____ .



I have something else to say.



How Sure Are You About Your Decision?



Not sure



a little sure



somewhat sure



sure



very sure

1

2

3

4

5



List Any Questions or Concerns

What Do I Do Next?

- Tell my doctor my decision
- Get more information
- Talk to a support person
- Schedule a date for surgery
- Try a non-surgery treatment at home
- Other

Credits and References

Credits	
Primary Medical Reviewer	

References

Ottawa Personal Decision Guide, O'Connor, Stacey, Jacobsen. Ottawa Hospital Research Institute & University of Ottawa, Canada, 2015

Healthwise Incorporated, Personal Decision Guide for Making Health Decisions, Carpal Tunnel Syndrome.

Note: The information in this guide does not replace the advice of a doctor.



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PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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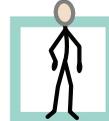
Patient Identification



My doctor (Dr. _____) will do my surgery.



The surgery is called: _____.



Procedure Site: The surgery is for this part of my body: _____.



PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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Patient Identification



My doctor told me that other health care workers may help



with my surgery.



The health care workers might be:



1. doctors who work with my doctor.



2. nurses



3. doctors who are learning to do the surgery.



PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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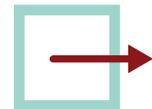
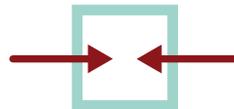
Patient Identification



Risks are bad things and benefits are good things that can happen



from my surgery. My doctor told me the risks and benefits from



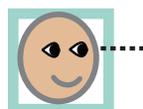
my surgery. The risks could happen during my surgery or after.



Risks



I understand that these bad things could happen from my surgery:



My doctor told me that an **observer may watch my surgery.**



PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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Patient Identification



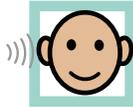
These are sometimes students and sometimes people who



support or sell surgical equipment.



My doctor told me that health care workers might take photographs,



videos, or sound recordings of my surgery. It is ok for the pictures or recordings to be used for other doctors to learn the procedure or if my medical insurance needs them to pay my bill.



My doctor asked me if I wanted more information.



I understood my doctor and had time to ask questions.



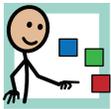
PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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Patient Identification



My doctor told me about the surgery and told me about my other



options, including no treatment. I agree to have the surgery.

_____/_____/_____: ____ am ____ pm
(Patient's Signature*) (Print First/Last Name) (Date) (Time)

I EXPLAINED THE ABOVE PROCEDURE(S) OR TREATMENT TO THE PATIENT:

_____/_____/_____: ____ am ____ pm
(Qualified Personnel's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

Check to indicate patient has signed using a name, word, mark or symbol other than legal name.

* Patient is unable to consent because: _____

If the Patient is unable to consent, complete Section A, B or C below, as applicable.

A. The patient has a Legally Authorized Health Care Representative:

As the Patient's (check **one**): Parent (if patient is a minor); Legal Guardian; Health Care Representative;
 Relative Caregiver (requires a°da vit), I give my permission and consent for the patient to the treatment(s) or procedure(s) speciyed above:

_____/_____/_____: ____ am ____ pm
(Authorized Consenter's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

I EXPLAINED THE ABOVE TREATMENT(S) OR PROCEDURE(S) TO THE PATIENT LEGALLY: AUTHORIZED HEALTH CARE REPRESENTATIVE.

_____/_____/_____: ____ am ____ pm
(Qualified Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)



**PATIENT INFORMED CONSENT
FOR RENDERING OF MEDICAL SERVICES/
SURGICAL SERVICES/SEDATION**

Continued from Page 4 (if applicable)

Patient Identification

B. The patient does NOT have a Legally Authorized Health Care Representative:

As the patient's (fill in relationship to patient) _____, I agree that the treatment(s) or procedure(s) have been fully explained to my satisfaction, is in the best interest of _____, and I consent for the patient:

_____/_____/_____ : am pm
(Consester's Signature) (Print First /Last Name) (Date) (Time)

I ATTEST :

- THE PATIENT'S INCAPACITY HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD
- THE MEDICAL NEED FOR THE PROCEDURE OR TREATMENT HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD, AND
- I HAVE EXPLAINED THE ABOVE PROCEDURE(S) OR TREATMENT TO THE CONSESTER NAMED ABOVE:

_____/_____/_____ : am pm
(Qualified Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

C. The patient does NOT have a Legally Authorized Health Care Representative OR any family member/friend that can be reasonably located or is willing to represent the patient's interests:

I ATTEST :

- THE PATIENT'S INCAPACITY HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD
- THE MEDICAL NEED FOR THE PROCEDURE OR TREATMENT HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD, AND
- THE HEALTH CARE SURROGATE COMMITTEE HAS CONSENTED TO THE PROCEDURE OR TREATMENT ON THE PATIENT'S BEHALF AND SUCH DECISION HAS BEEN DOCUMENTED.

_____/_____/_____ : am pm
(Qualified Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

FOR TELEPHONE CONSENTS:

_____/_____/_____ : am pm
(Witness' Signature for telephone consent only) (Print First /Last Name) (Date) (Time)

Mark this box if interpreter was involved with any of the signatures on this form.