

Meadow Lane Surgery Center

5652 Meadow Lane, New Port Richey, FL 34652

DISCHARGE INSTRUCTIONS

FOLLOW UP CARE: Return to Physician's office in _____ days.

MEDICATIONS: Resume all preoperative medications per prescribing physician's order.

Except the following: _____ .

PRESCRIPTIONS: Given to patient: _____

COMFORT MEASURES:

____ Keep the operative site elevated for _____ days.

____ Ice compresses to operative site for _____ day(s).

DIET: You may resume your usual diet

WOUND CARE: None

Keep dressing dry. Then clean area with peroxide and then apply a band aid or light dressing.

You may shower over the band aid and clean and reapply a dry band aid.

May remove dressing in _____ days _____ weeks _____ leave tape (steri) strips in place.

Change dressing: _____

First shower on: _____

ACTIVITY: You may return to normal activities _____ immediately or in _____ days.

Up as tolerated

Walk only when absolutely necessary for _____ days _____ weeks. (As to go to the bathroom)

Keep the operative site elevated for _____ days.

NORMAL EXPECTATIONS:

Discomfort at operative site.

Minimal bleeding from incision site.

ANESTHESIA PRECAUTIONS:

Do not operate a motor vehicle, machinery, make important decisions or drink alcohol until tomorrow.

CALL YOUR DOCTOR:

1. Temperature of 101° F or higher or chills.
2. Excessive bleeding from incision site.
3. Unrelieved pain.

Physician's Phone Number

!!! IN AN EMERGENCY CALL 911 !!!

The above instructions have been reviewed with me.

Signature of Patient or Significant Other

Nurse's Signature

Date

Physician's Signature

#90 Post-Op Instructions-Ortho 03/09

Addressograph

Post-operative Call

Procedure: _____ Phone # _____

Date of Procedure: _____ Surgeon: _____

	Yes	No	Comments
1. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. IV Site Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Drainage from Incision	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Amount: _____
9. Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Resting	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Ambulatory	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Slight <input type="checkbox"/> None

Patient's General Comments: _____

Nurse's Notes: _____

Complications Reported: N/A Yes Reported To: _____

Date of Call: _____ Time: _____

_____ No Answer

Signature of Nurse

Re-Call Date: _____ Time: _____

_____ No Answer

Signature of Nurse

Addressograph