



0400002

PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

ORIGINAL – MEDICAL RECORDS COPY –PATIENT

POST-SEDATION / POST-PROCEDURE DISCHARGE INSTRUCTIONS

Procedure: _____

Diet:

- Clear liquids the rest of today
- Clear liquids, then bland soft foods, then progress to regular diet
- Resume normal diet
- Drink no alcohol for the rest of the day

Activity: for the rest of the day

- Rest and quiet activity at home; you may be unusually tired today
- Do not drive any vehicle or operate any heavy machinery
- Delay making critical personal or business decisions
- Resume your normal activity, including work/school
- May return to work/school tomorrow
- For sedated children: supervise for the rest of the day and watch closely for staggering or falls

Medications:

Do not take cold medicines or sleeping medicines today.

- Resume all regular medications
- Other: _____
- New prescription: Medication _____ Dose _____ Schedule _____
Medication _____ Dose _____ Schedule _____

Instructions:

Side effects you/your child may experience: nausea, vomiting, sleepiness, blurred vision, unsteadiness

Call your doctor or one of the numbers below if any of these occur: difficulty breathing; rash; itching and swelling of hands, face or eyes; exceptional drowsiness, dizziness, continued vomiting/can't keep fluids down

- The IV site may be sore for a day or two. Warm compresses may help. If the area becomes red, swollen, hot or painful, call one of the numbers below.
- Always wash your hands before and after caring for any wound.

Follow Up:

The person who did your procedure today was: _____

- If you have questions call: _____
- After hours call (434) 924-0000 and ask for the doctor on call for _____

After hours call the Emergency Department at (434) 924-2231

Patient escorted by _____ who accepts responsibility for the patient.

Patient discharged via wheelchair ambulatory other _____ with all belongings.

I understand the above information: _____ Date: _____
(Patient's/Responsible Family Member's Signature)

Physician/Nurse Signature _____ Title: _____ Pic #: _____ Date: _____

Interpreter's Signature _____ Title: _____ Pic #: _____ Date: _____