



0400002

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

NEURORADIOLOGY VERTEBROPLASTY DISCHARGE INSTRUCTIONS

1. DIET:

- a) Resume your regular diet as tolerated.
- b) Do not drink alcohol for 24 hours following the procedure.

2. ACTIVITY:

- a) Do not lift more than five pounds for one week.
- b) Do not drive or operate heavy machinery for twenty-four hours.
- c) Avoid strenuous activity for twenty-four hours.
- d) You may shower twenty four hours following the procedure.
- e) Do not use hot tub, bath tub or swimming pool for one (1) week.

3. MEDICATIONS:

- a) Resume your regular medications today.
- b) You may take ibuprofen, aspirin or Tylenol if you experience mild discomfort at the procedure site.
- c) If necessary, you may take physician prescribed pain medication later in the evening.

4. DRESSING:

- a) You may remove the original dressing after twenty four hours. Keep procedure site covered with a band aid for five days. Change the band aid daily.

5. FOLLOW-UP INSTRUCTIONS:

- a) You will need to have an xray of your spine taken in six months. The radiology request that you have been given today provides the information needed to have the test. You may elect to have the xray completed in your hometown area or you may return to the radiology department here to have the follow up xray done.

ALERT: CALL 911 AND GO TO THE NEAREST EMERGENCY IF YOU EXPERIENCE SHORTNESS OF BREATH OR CHEST PAIN

CALL US IF YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS:

- NEW PAIN OR INCREASE IN PAIN LEVEL
- FEVER OR CHILLS
- REDNESS, SEVERE PAIN OR SWELLING AT THE PUNCTURE SITE

If you have any questions or problems please call:

Neuroradiology: Monday - Friday (8:00 am - 5:00 pm) Phone 434-924-5213.

All other times: local 924-9400 or toll free 1-877-817-3865 and press 1 for receptionist.

PROCEDURE PERFORMED: _____ BY DOCTOR: _____

MEDICATION GIVEN:

DRUG: _____ DOSAGE _____ LAST DOSE _____

DRUG: _____ DOSAGE _____ LAST DOSE _____

DRUG: _____ DOSAGE _____ LAST DOSE _____

I have been given and understand the above information: _____
Patient/Responsible Family Signature

Reviewed by: _____ Title/PIC _____ Date/Time: _____

I accept responsibility for safe discharge of the above patient: _____

INTERPRETER ATTESTATION (when applicable)

Translation has been provided by: _____
Signature of Interpreter/CyraCom ID #

Recibi una copie traducida de este documento. Patient Initials: _____ Form #: _____
(I have received a translated copy of this document.)

White Copy - Medical Records Yellow Copy - Patient