



0400002

PLACE LABEL HERE.

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

NEURORADIOLOGY DIVISION - DISCHARGE INSTRUCTIONS VERTEBROPLASTY

ONLY THOSE ITEMS CHECKED ARE YOUR PERSONAL INSTRUCTIONS:

1. DIET INSTRUCTIONS

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

2. ACTIVITY INSTRUCTIONS

- Do not lift more than five (5) pounds for one (1) week.
- Do not drive or operate heavy machinery for 24 hours.
- Avoid strenuous activity for 24 hours.
- You may shower 24 hours following the procedure.
- Do not use hot tub, bath tub or swimming pool for one week.

3. MEDICATION

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

4. DRESSING

- You may remove the original dressing after 24 hours. Keep procedure site covered with a band-aid for five (5) days. Change the band-aid daily.

5. FOLLOW UP INSTRUCTIONS

- 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.

Procedure Performed: _____ By Dr. _____

Medications Given: Drug _____	Dosage _____	Last Dose _____
Drug _____	Dosage _____	Last Dose _____
Drug _____	Dosage _____	Last Dose _____
Drug _____	Dosage _____	Last Dose _____

ALERT: CALL 911 AND GO TO THE NEAREST EMERGENCY DEPARTMENT 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
- REDNESS, SEVERE PAIN OR SWELLING AT THE PUNCTURE SITE
- FEVER OR CHILLS

IF YOU HAVE ANY QUESTIONS OR PROBLEMS PLEASE CALL:

NEURORADIOLOGY: 8 AM - 5:00 PM, Monday - Friday, phone 434-924-5213.

All other times: 1-800-972-9882 or 1-434-924-9400 (Radiology Operator) and ask for the "On Call" Neuroradiologist.

I have been given and understand the above information _____
(PATIENT/RESPONSIBLE ADULT SIGNATURE)

Reviewed by _____ Title/PIC _____ Date/Time _____
STAFF NAME / SIGNATURE

If Translated: INTERPRETER ATTESTATION (when applicable)
Translation has been provided by: _____ Date/Time _____
SIGNATURE OF INTERPRETER/CYRACOM ID#

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