



0400002

PLACE LABEL HERE.

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

**NEURORADIOLOGY DIVISION - DISCHARGE SHEET
CARE AFTER OUTPATIENT MYELOGRAM / LUMBAR PUNCTURE / CISTERNOGRAM**

Date _____ Time _____ Procedure performed _____ Discharge time _____

Discharge to: Self Family Friend Nurse/attendant _____

Transportation: Ambulatory Wheelchair Stretcher _____ NAME

Belongings returned to: Self Family Friend _____

NAME

ONLY THOSE ITEMS CHECKED ARE YOUR PERSONAL INSTRUCTIONS:

1. DIET INSTRUCTIONS

- You may resume your regular diet.
- Drink plenty of fluids. We suggest you drink at least one 8-ounce glass per waking hour for 24 hours.
- Avoid alcohol for 24 hours.

2. ACTIVITY INSTRUCTIONS

- Relax the rest of the day. Sit comfortably. If you lie down, use at least two (2) pillows under your head. You may lie flat after 24 hours.
- Avoid strenuous activities for at least one day after your procedure.
- You had a Lumbar Puncture; you may lie flat after your procedure.
- We suggest you do not drive for the rest of the day after the procedure.

3. DISCHARGE INSTRUCTIONS

- Headache and nausea may develop but are usually mild and transient. However, if they become severe or other symptoms develop, call one of the numbers below.
- Your procedure injection site may feel sore through tomorrow. If the site has any fluid leakage, becomes hot, red, swollen, or painful, please call the phone number below.
- If it was necessary for you to have an IV, the site may feel sore through tomorrow. Warm compresses may make it more comfortable. If the site becomes hot, red, swollen, or painful, please call the phone numbers below.
- The results of your test will be sent to the doctor who referred you for the test. Your doctor will contact you regarding the test results. Allow one week from the day of the procedure then call the referring physician's office for results.

4. MEDICATION INSTRUCTIONS

- If any of your medications were placed on hold for this procedure, you may resume those medications 24 hours after the procedure was completed. This would be on _____ (time) _____ (date).

IF YOU HAVE ANY QUESTIONS PLEASE CALL:

1. From 8 AM - 4:30 PM, Monday - Friday, ask for one of the nurses at 434-924-5213 (Neuroradiology Department).
2. Otherwise call: local 924-9400 or toll free 1-877-817-3865 and press 1 for receptionist.

I have been given and understand the above information: _____
(PATIENT/RESPONSIBLE FAMILY 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 # _____