

## PAIN MANAGEMENT DISCHARGE INSTRUCTIONS:

### FOLLOW UP CARE:

1. See your pain management doctor as scheduled or call for any concerns you might have, such as an increase in temperature or increase in pain.
2. Check you temperature 2 times a day for 2-3 days and report an elevation of 101 degrees or greater to your pain management doctor.
3. Check injection site for any signs of redness, swelling, bruising, drainage or pain and report any of these symptoms to your pain management doctor.
4. **SHOWER ONLY!!** No tub baths, swimming or jacuzzi's for 24 hours.
5. You may experience weakness in your extremities from the injection. If it persists for more than a day, report it to your pain management doctor.

### COMFORT MEASURES:

1. You may apply an ice pack or warm moist compress to the injection site for comfort if needed.

### MEDICATIONS:

1. Resume all medications. You may take your pain medications if needed.
2. **DIABETICS:** Due to the steroid injection you may see an increase in your blood sugar. If it persists for more than 24-48 hours, report it to your primary doctor.

### ANESTHESIA PRECAUTIONS:

1. **DO NOT** operate motor vehicles, any heavy lifting, operating of heavy machinery or strenuous activity for 24 hours after you procedure.
2. **DO NOT** drink alcohol for the next 24 hours.
3. **DO NOT** make any important decisions for the next 24 hours.
4. If you receive a spinal anesthesia you may experience some discomfort in your lower back.

**IN THE EVENT OF AN EMERGENCY CALL 911! Physician's Phone Number \_\_\_\_\_**

The above instructions have been reviewed with me.

Patient Label

\_\_\_\_\_  
Signature of Patient or Significant Other

\_\_\_\_\_  
Nurse's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

# 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