Your Attending Surgeon is Dr. ___________________ and the office number is (415) 206- 4093

WHEN YOU GO HOME…..

Activity

Resume your normal activities as tolerated
Activity level to be directed by your Rehabilitation program
You may return to work on _________
Do not work until seen and cleared by the Neurosurgery Service at your follow-up clinic appointment
You may bear weight as tolerated
Do not bear weight on _______________________________
Do not lift heavy objects (more than 10lbs) until ________

Catheter Care

Before each catheterization, attempt to urinate and write down the amount.
Wash catheter site with soap & water each day. Rinse well.
Perform straight cath every 4 hours. **Wash Hands** and organize equipment on clean surface. Wash genital area and insert with clean technique.
Empty leg bag every 4 hours as needed and record amount.

Wound Care

Remove the bandage on ______
It is ok to shower, pat wound dry. Do not rub
Do not bathe or shower until your staples / stitches are removed
Remove steri-strips on ________
Other: _____________________________________

Brace

You should wear your Collar / Brace at all times
You may remove your brace/collar for bathing
You may remove your brace when lying flat in bed

Bowel Care

Insert suppository and perform digital stimulation everyday as instructed during your hospital stay.

Other Information

Do not take asprin, motrin, advil, naprosyn, alieve or Additional non-steroidal medications until cleared by Neurosurgery

____

If you have any of these problems: Call the neurosurgery clinic @ ______________ or go to the Emergency Department

Fever more than 101 degrees
Redness, swelling, pus-like drainage from your wound
Bleeding from your wound
Skin rash, difficulty breathing or swallowing
Severe pain unrelieved by pain medication or pain that is getting worse
Slurred speech
Repeated vomiting
Difficulty arousing
Increase confusion,restlessness, or agitation
Seizures
Weakness, numbness or decreased coordination
Other: ________________________________

Physician/Nurse Practitioner/Physician Assistant	**Registered Nurse** The patient/family demonstrates understanding of these instructions.
Date: Signature:	Date: Signature:

Patient/Family I understand these instructions and have a copy of them.	**Interpreter (if applicable)**
Date: Signature:	Date: Signature: