ROCKY MOUNTAIN SURGICAL CENTER

Pain Management Discharge Instructions

MR #

Case ID #

DOS

Patient Name

DOB

Age

Sex

Surgeon

Scheduled Procedure

Doctor:

If you experience problems that you feel warrant the attention of a physician and cannot reach your surgeon through his / her office number, please call Bozeman Deaconess Hospital at 406-585-5000 to have the surgeon on call paged or go to the nearest emergency room. In the event of an extreme emergency please dial 911.

☐ Epidural Injections ☐ Nerve Root Injections ☐ Radio Frequency Ablation

☐ Other: _____

☐ No driving for 24 hours

☐ Lay down for the next 1-2 hours

☐ Reduced activity for 48 hours (no bending or lifting)

☐ Continue use of current pain medication. It is not unusual to experience increased discomfort during the first 24-48 hours.

☐ Ice pack for first 1-2 hours then as needed to decrease pain at injection site

☐ No heat to injection site for 48 hours, including bath tub or hot tub

☐ Resume diet

☐ Other: _____

☐ Cervical

Notify your physician if any of the following problems occur:

☐ Increased neck or arm pain

☐ Increased arm numbness or weakness

☐ Drainage from injection site

☐ Fever over 101°

☐ Excessive redness or bleeding at injection site

☐ Headache in an upright position relieved when lying flat

☐ Any difficulty swallowing or breathing from excessive neck swelling

☐ Be aware, if you are diabetic, steroids may cause an increase in your blood sugar for the next couple of days

☐ Other instructions: _____

☐ Thoracic ☐ Lumbar ☐ Sarcoiliac

Notify your physician if any of the following problems occur:

☐ Increased back or leg pain

☐ Increased leg numbness or weakness

☐ Drainage from injection site

☐ Fever over 101°

☐ Excessive redness or bleeding at injection site

☐ Headache in an upright position relieved when lying flat

☐ Bowel or bladder difficulties

☐ Be aware, if you are diabetic, steroids may cause an increase in your blood sugar for the next couple of days

☐ Other instructions: _____

Return Appointment: _____

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The above discharge instructions have been received and understood by me.

Relationship

Date

Signature _____

Signature of Nurse Reviewing Instructions

Date

Time