**Discharge Lumbar**

**DISCHARGE NOTE**

**ADMITTING PHYSICIAN**: Amit Bhandarkar, M.D.

**PROVIDER**: Amit Bhandarkar, M.D., Prairie Spine and Pain Institute

**ADMISSION DATE**: [Insert Admission Date]

**DISCHARGE DATE**: [Insert Discharge Date]

**OPERATIVE NOTES**:

* The patient underwent surgery for spondylolisthesis and associated issues, achieving wide decompression, discectomy, disc height restoration, bone grafting, and anterior instrumentation.
* Blood transfusion: None.

**HISTORY OF PRESENT ILLNESS**:

The patient has a long-standing history of low back pain and radicular symptoms. He has failed back surgery syndrome following two prior spine surgeries. Symptoms include predominantly left-sided radicular pain in the L3-L4 distribution and axial back pain due to spondylolisthesis at L3-L4. Conservative management failed to provide relief. The patient also has a history of poorly controlled diabetes.

**HOSPITAL COURSE**:

* **Surgery**: The patient underwent a successful procedure with minimal intraoperative bleeding and no complications. Postoperative objectives, including decompression and stabilization, were achieved.
* **PACU**: Pain managed effectively with morphine and fentanyl, reducing pain levels to a manageable range.
* **SCU**:
	+ Pain management included morphine, hydrocodone, IV acetaminophen, and lidocaine patches.
	+ Sequential compression devices were used for DVT prevention.
	+ Antibiotics were administered for three doses, with no signs of infection.
	+ Physical therapy initiated, focusing on gradual mobilization.
	+ Incentive spirometry and respiratory therapy provided.
	+ Diet advanced from liquids to normal as tolerated.
	+ No urinary or respiratory complications.

**EXAMINATION AT DISCHARGE**:

* **Vitals**: Stable, no fever.
* **Physical Examination**:
	+ **HEENT**: Oral membranes moist, PERRLA, EOMI, no nystagmus.
	+ **Neck**: Supple.
	+ **CV**: Regular rate and rhythm, no murmurs, gallops, or rubs.
	+ **Resp**: Clear to auscultation bilaterally.
	+ **Abd**: Soft, non-tender, non-distended.
* **Pain and Function**: Operative site pain reported as burning with occasional spasms. Left leg pain significantly improved. No fever, inflammation, or infection noted. Neurologically intact.

**DISCHARGE MEDICATIONS**:

1. Norco 7.5 mg orally every 4-6 hours as needed for severe pain (gradual weaning encouraged).
2. Lidoderm patches for localized pain relief.
3. Tramadol 50 mg (2 tablets every 2 hours as needed for pain).
4. Gabapentin 300 mg three times daily.

**DISCHARGE INSTRUCTIONS**:

1. Follow prescribed pain management protocol, including gradual weaning from medications. Call the office if pain increases or changes.
2. Maintain a normal diet as tolerated.
3. Keep dressings in place for five days and remove the superficial layer afterward. Avoid wetting dressings.
4. Schedule a follow-up appointment in two weeks.
5. Resume all home medications. Medical reconciliation has been sent to the primary care provider.
6. Engage in normal activities of daily living, avoiding lifting, bending, twisting, or prolonged sitting (>30 minutes). Use an abdominal brace for comfort.
7. Continue physical therapy, starting two weeks after discharge.
8. Follow hospitalist recommendations for managing hypertension, diabetes, hypothyroidism, and other conditions.
9. Contact the office for any signs of dressing discharge or soakage.
10. Practice strict blood sugar control and avoid smoking.
11. Continue chest physical therapy and breathing exercises at home.
12. Contact Prairie Spine with any concerns using the provided phone number.