DISCHARGE SUMMARY LUMBAR SPINE

DATE OF ADMISSION

DATE OF DISCHARGE

HISTORY OF PRESENT ILLNESS:

**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 COURSE**:

The surgery was uneventful, with all objectives achieved. Estimated blood loss during the procedure was approximately \_\_\_ cc.

**PACU STAY**:

After surgery, the patient was transferred to the PACU for monitoring. Her course was uneventful, and pain relief was achieved with fentanyl and morphine loading. Pain control was initiated with PCA morphine before transferring the patient to the SCU.

**SCU STAY**:

* **Pain Management**: Pain levels were controlled and maintained at a tolerable range (3-4) using a multimodal approach, including acetaminophen, morphine, Toradol, gabapentin, and Lidoderm patches.
* **Foley Catheter**: The Foley catheter was removed on postoperative day 1.
* **Surgical Drain**: The drain was removed on postoperative day 1 after output reduced to less than 150 cc in a shift.
* **Physical Therapy**: The patient was mobilized gradually out of bed with physical therapy assistance. She was able to stand, sit, and walk using a brace.
* **Respiratory Therapy**: The patient received nebulization and chest physiotherapy for respiratory care.
* **DVT Prophylaxis**: Sequential compression devices and stockings were utilized throughout her stay to prevent VTE.

**MED/SURG UNIT STAY**:

* **Pain Management**: After being stable in SCU, the patient was transferred to the Med/Surg Unit. PCA was withdrawn, and oral analgesics were initiated.
	+ Pain management was optimized with Norco 10 mg every 4-6 hours as needed for severe pain, gabapentin 300 mg three times per day, and Lidoderm patches. Pain at the operative site persisted but was expected to improve with time.
* **Physical Therapy**: The patient engaged in corridor walking and other activities of daily living.
	+ **Leg Pain**: Complete resolution of her preoperative leg pain (rated as 0). Numbness in her left leg showed improvement following the excision of the synovial cyst.
* **Functional Status**: The patient passed urine comfortably, passed flatus, and tolerated oral fluids and a normal diet.
* **Postoperative X-rays**: Imaging showed implants in proper position.
* **Lab Results**: Hemoglobin on discharge was \_\_\_ g/dL, and all other labs were within normal limits.

**PHYSICAL EXAMINATION AT DISCHARGE**:

* **Vital Signs**: Stable.
* **Chest**: Clear to auscultation.
* **Abdomen**: Soft and non-tender.
* **Extremities**: No signs of VTE; extremities pink and warm.
* **Motor Strength**: 5/5 in all extremities.

**DISCHARGE INSTRUCTIONS**:

1. **Medications**: Continue Norco \_\_\_ mg by mouth every 4-6 hours as needed for severe pain, with gradual weaning over time.
2. **Diet**: Resume a normal diet as tolerated.
3. **Wound Care**: Keep dressings on; showering is allowed but avoid rubbing the dressings.
4. **Activity Restrictions**:
	1. Avoid lifting, bending, twisting, and sitting for more than 30 minutes.
	2. Use a brace for comfort during activities.
5. **Follow-Up**: Schedule a follow-up appointment in two weeks. Physical therapy will begin after this visit.
6. **Home Medications**: Resume all home medications as prescribed.
7. **Detailed Instructions**: A detailed discharge instruction sheet has been provided.
8. **Contact Information**: For questions or concerns, the patient can contact Prairie Spine and Pain Institute at the provided phone number.

**ADDITIONAL RECOMMENDATIONS**:

* Maintain a tolerable level of activity, with gradual increases as pain allows.
* Monitor for signs of infection or dressing issues and report immediately if noticed.