**Discharge Summary Template Lumbar**

**DISCHARGE SUMMARY**

**DATE OF ADMISSION AND SURGERY**: [Insert Date]

**DATE OF DISCHARGE**: /2017

**PREOPERATIVE DIAGNOSIS**: Chronic low back pain and radiculopathy in the L4-L5-S1 distribution secondary to segmental instability with mild spondylolisthesis at L4-5, severe back pain, and degenerative disc disease.

**POSTOPERATIVE DIAGNOSIS**: Same as preoperative.

**SURGERY PERFORMED**:

Transforaminal lumbar interbody fusion (TLIF) at L4-5 and L5-S1 with wide decompression, discectomy, interbody fusion, and bone grafting using a midline open technique.

**HISTORY OF PRESENT ILLNESS**:

The patient presented with a longstanding history of low back pain and radicular pain primarily affecting the left lower back and leg. Symptoms were associated with segmental instability, mild spondylolisthesis at L4-5, and narrowing of the lateral recess from degenerative disc disease. Conservative management, including physical therapy and injections, had failed to provide adequate relief.

**HOSPITAL COURSE**:

On admission, the patient underwent TLIF at L4-5 and L5-S1. The surgery was uneventful, with an estimated blood loss of \_\_\_ cc. Postoperatively, the patient was extubated in the OR and transferred to PACU, where pain was stabilized using morphine and fentanyl (pain level 4). The patient was then transferred to SCU for further management.

**SCU**:

* **Pain Management**:
* Pain was managed with morphine, oral hydrocodone, IV acetaminophen, and lidocaine patches. Lidoderm patches and gabapentin were continued. Pain levels were well controlled.
* **Antibiotics**:

Preoperatively and intraoperatively, vancomycin was administered due to MRSA swab positivity. Antibiotics were continued until drain removal.

* **DVT Prophylaxis**:

Sequential compression devices were used throughout the stay.

* **Catheter and Drain Management**:

A urinary catheter was removed on postoperative day 2. A single deep drain was removed after two days when output decreased.

* **Comorbidities**:

Diabetes and hypertension were managed by the hospitalist.

* **Fever**:

Two mild febrile episodes on postoperative day 2 were noted but resolved without incident.

* **Physical Therapy**:

Gradual mobilization out of bed and walking without support were achieved. The patient received respiratory therapy, including incentive spirometry.

* **Diet**:

Advanced from liquids to a regular diet. The patient passed gas but had no bowel movement; Dulcolax was administered.

**DISCHARGE EXAMINATION**:

On the day of discharge (postoperative day 3):

* **Vital Signs**: Stable. No fever.
* **Physical Exam**:
  + HEENT: Oral mucosa moist, PERRLA, EOMI, no nystagmus.
  + Neck: Supple.
  + CV: Regular rate and rhythm, no murmurs, gallops, or rubs.
  + Resp: Clear to auscultation bilaterally.
  + Abdomen: Soft, non-tender, non-distended.
  + Extremities: No edema; distal pulses intact.
  + Neurological: 5/5 motor strength in all extremities; improving sensations in lower limbs.
* **Wound**: Dressing dry and intact, no signs of inflammation.

**DISCHARGE INSTRUCTIONS**:

1. **Medications**:
   1. Continue oral hydrocodone \_\_\_ mg every 4-6 hours as needed for severe pain, gradually weaning.
   2. Continue Lidoderm patches and gabapentin 300 mg three times daily.
   3. Take tramadol 50 mg, two tablets every 2 hours as needed for pain.
   4. Contact the clinic if there is increased pain or a change in pain pattern.
2. **Diet**: Normal diet as tolerated.
3. **Wound Care**:
   1. Keep dressings in place for five days, then remove the superficial layer. Avoid wetting the dressings.
4. **Activity Restrictions**:
   1. Resume normal daily activities but avoid lifting, bending, twisting, or sitting for more than 30 minutes.
   2. Continue wearing an abdominal brace for comfort.
5. **Follow-Up**:
   1. Follow up in two weeks. Physical therapy will resume after this visit.
   2. Continue to follow hospitalist recommendations for hypertension, hypothyroidism, and other conditions.
   3. Contact the family physician upon discharge.
6. **Physical Therapy and Respiratory Therapy**:
   1. Continue chest physical therapy and breathing exercises at home.
   2. Engage in gentle mobility exercises as tolerated.
7. **Emergency Contact**:
   1. In case of dressing issues (discharge or soakage), call Prairie Spine and Pain Institute at the provided number.

**DISCHARGE PLAN**:

The patient is stable and fit for discharge with improving symptoms.

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