

Scott K. Stanley, M.D.

Dear New Patient:

Welcome to Denver-Vail Orthopedics, P.C. and thank you for making an appointment with us for your spine care. Spine disorders are complicated to diagnose and my practice utilizes a team approach to give you the best possible care. When you arrive, you will meet a variety of team members to assist me in your work up. This includes my medical assistant, spine nurse practitioner, and radiology technicians. Be assured that we individualize your care and want to make your visit as efficient and productive as possible.

In order to respect your appointment time and the appointments of other patients, we ask that you bring a few items to your first visit.

- 1) The enclosed patient questionnaire, patient information sheet, and pain management contract should be **completed** prior to arrival.
- 2) MRIs, CT scans, 1 or x-rays, either on film or CD. Reports are **not** sufficient. (If you have not had imaging studies, you will be evaluated for their need at the time of your visit)
- 3) Insurance card and/or Worker's Compensation information

Please arrive 15 minutes prior to your scheduled appointment to process your paperwork. If you are unable to complete and bring these items, or arrive after your specified appointment time, we will respectfully ask you to reschedule in order to make your appointment more productive. We understand that there are occasionally extenuating circumstances and we will try to accommodate these situations. Please be aware that your initial evaluation appointment could take up to 90 minutes, so please schedule accordingly.

Please feel free to contact my staff prior to your visit with any questions or visit us on the web at www.denvervailorthopedics.com.

Warmest regards,

Scott K. Stanley, M.D.
Board-Certified Orthopaedic Surgeon
Fellowship-Trained in Spine

Please complete this form in blue or black ink

Denver Vail Orthopedics Patient Information

Patient ID: _____

Treating Physician: _____

Patient Name: _____

Preferred Name: _____ Sex: M F Marital Status: M S W D Partner

DOB: _____ Age: _____ S.S. # _____

Address: _____ City, St. Zip _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Work # _____

Referring Provider: _____ Primary Care Provider: _____

Referring Prov. Ph# _____ Primary Care Prov. Ph# _____

Referring Prov. Add: _____ Primary Car Prov. Add: _____

Emergency Contact: _____ Relation _____ Phone# _____

Emergency Contact Address (If different):

Insurance Card(s) Given to Receptionist to be scanned. Yes No

PLEASE COMPLETE IF POLICY HOLDER IS DIFFERENT THAN PATIENT.

Primary Insurance Information: Please Complete

Policy Holder Name _____ Primary Ins _____

Policy Holder DOB: _____ Policy ID # _____

Policy Holder _____ Group # _____
(if different from PT)

Policy Holder SS # _____

Policy Holder Employer: _____

Denver Vail Orthopedics Patient Information Continued

*****Other Insurance Information: (Secondary, Work's Comp, or Auto) PLEASE CIRCLE*****

Policy Holder Name _____ Other Insurance _____

Policy Holder DOB _____ Policy ID # _____

Policy Holder Address _____
(If different from pt) _____ **Group #/W. Comp Claim #** _____

Policy Holder SS# _____ Adjustor _____
Phone: _____ Fax: _____

Policy Holder Employer _____

Assignment of Benefits: Please remember that insurance contracts are made between the patient and the Insurance company. Often the insurance does not provide full payments of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Denver Vail Orthopedics, PC for services of myself.

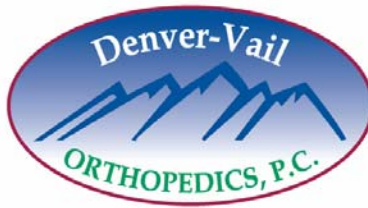
Date _____ Signed: X _____
"SIGNATURE ON FILE" will automatically print on your claim, allowing your insurance to pay us directly.

Records Release: I hereby authorize the release of any information, including medical and billing information, by Denver Vail Orthopedics, PC to my referring doctor or insurance company.

Date _____ Signed: X _____

Notice of Privacy: I have received a copy of the Notice of Privacy Practices from Denver Vail Orthopedics, PC

Date _____ Signed: X _____



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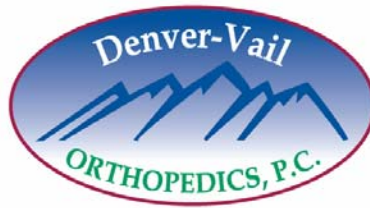
Patient Contract for Pain Management and Medication Agreement

This agreement between _____ (the patient) and _____ (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain medications. This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback, alternative therapies, physical therapy and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The medication will probably not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

____1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opioid painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include. But are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.



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____ 2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medication prescribed to me.

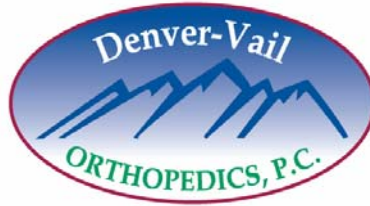
____ 3. I realize that all medication have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

____ 4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids, and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

____ 5. I understand I must contact my physician before taking tranquilizers, prescription sleeping medications, and any over-the-counter medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

____ 6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. Narcotic pain medications are used in this clinic for treatment of acute or short-term pain, such as pain experienced after an injury. The amount of narcotics taken for any condition will be limited in order to prevent the body from building up a tolerance to the medication.

____ 7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.



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___ 8. It is important to remember that other techniques may be used in place of narcotics for symptom control.

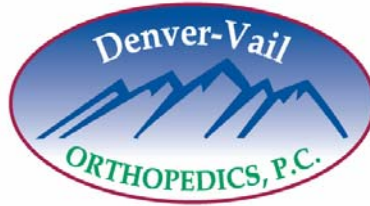
These include ice/heat, massage, deep breathing and relaxation techniques, and use of over-the-counter medications such as Extra Strength Tylenol (check with physician before beginning any over-the-counter medication). I agree that continued prescribing of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

___ 9. Timely requests for refills of medications are the patient's responsibility.

- A. Refill requests for medication requiring a written prescription must be called to the office 48 business hours prior to pickup. Written prescriptions must be picked up at the office.
- B. Refills must be called in before 4:00 PM Monday-Thursday, and before 2:00 PM on Friday. Prescription refills will not be issued after these hours or on the weekends by the on-call physician.
- C. Refills will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if some one else has taken some of your prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- D. Refills will not be made as an "emergency". I will call my pharmacy at least 2 days prior to needing my prescription(s) that do not require a written prescription.
- E. If medications are stolen, and a police report regarding the theft is completed, an exception may be made at the discretion of my physician.

___ 10. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my physician.

___ 11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.



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___12. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

___13. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

___14. I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

___15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

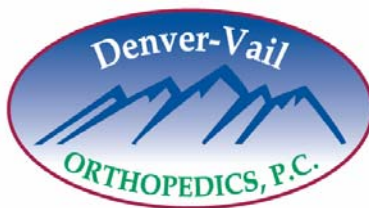
___16. **I understand that if am receiving pain medications from multiple doctors, Denver Vail Orthopedics, PC will discontinue prescribing pain medications and I will be dismissed from the practice.**

___17. I agree that I will submit to a blood and/or urine test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

___18. I understand that once I reach maximum medical improvement postoperatively management of my refills will be transferred to a pain management physician or my primary care physician. If I do not have either a pain management physician or a primary care physician, I will have from 1 to 3 months to find a doctor that will take over my care and prescribe my medications.

___19. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen may be tapered or possibly discontinued and my care referred back to my primary care physician.

___20. I will keep all scheduled follow up appointments as outlined in my treatment plan.



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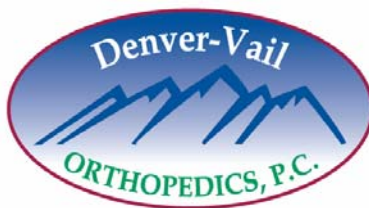
___21. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

___22. I agree to receive pain medications exclusively from the following provider _____.

___23. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications and I authorize the doctors, my pharmacy, and insurers to cooperate fully with any city, state, or federal agency in the investigation of any possible misuse, sale, or other diversion of my pain medication.

___24. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

___25. My physician and I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.



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I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by my physician. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your physician **in no way invalidates** any other provisions of this agreement.

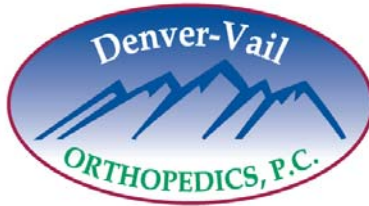
If at any time you are concerned about your medication or side affects of your medication, you should notify the medical assistant at Denver Vail Orthopedics, PC at 720-974-5200. The on-call physician can also be contacted to receive your message if necessary.

I agree to use _____ Pharmacy, located at _____ telephone number _____, for **all** my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____ day of _____, 20____.

Patient Signature _____

Physician Signature _____



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Spine Health History

Date: / /

Name: _____

DOB: / /

Age: _____

Handedness: Right Left

Sex: Male Female

Who referred you to us? _____

What do you hope we can accomplish today?

Use the symbols below to draw the type and location of the pain you feel.

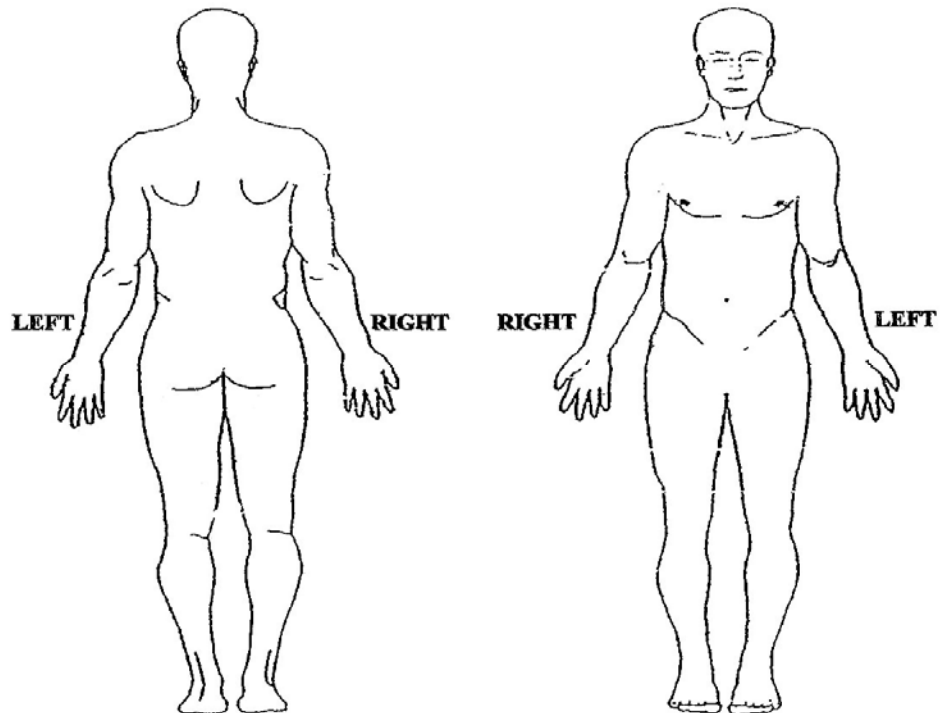
Aching * * *

Numbness = = =

Pins and needles O O O

Burning X X X

Stabbing / / /

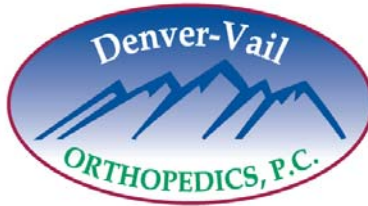


Circle your pain on a scale of 0 to 10 with 10 being the worst imaginable pain

Today: 0 1 2 3 4 5 6 7 8 9 10

Good Day: 0 1 2 3 4 5 6 7 8 9 10

Bad Day: 0 1 2 3 4 5 6 7 8 9 10



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Spine History

Tell us about your symptoms:

When did your symptoms begin? _____

How did your symptoms begin? Gradually Suddenly Specific Injury

Do your symptoms radiate to your arms or legs? Yes No

Do you have pain/numbness/tingling at night? Yes No

Do you have weakness in your arm(s) or leg(s)? Yes No

My symptoms are: Constant Intermittent

What activities increase your symptoms?

Walking Sitting Standing Lying Position Change

What activities improve your symptoms?

Walking Sitting Standing Lying Position Change

What makes your symptoms worse? _____

What makes you symptoms better? _____

Have you lost control of your bowel or bladder function? Yes No

Tell us about your activity level:

Do you exercise? Yes No # days/week: _____

What type of exercise do you do? _____

How do your symptoms limit your activity level?

Not at all I have to limit some activities My activities are extremely limited

Have you had any of the following treatments?

Did this treatment help?

Physical Therapy: Yes No Yes No

Chiropractor: Yes No Yes No

Massage Therapy: Yes No Yes No

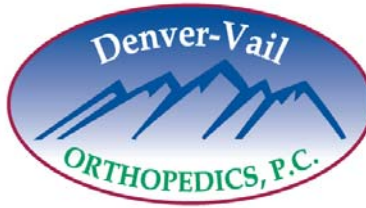
Acupuncture: Yes No Yes No

TENS Unit: Yes No Yes No

Brace: Yes No Yes No

Have you had injections for this problem? Yes No

Type (circle one)	Date	Immediate relief?	Length of relief?
Epidural Nerve Block Trigger Point	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epidural Nerve Block Trigger Point	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epidural Nerve Block Trigger Point	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



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Have you had previous neck/back surgery? Yes No

Date	Surgery Type	Surgeon
/ /	_____	_____
/ /	_____	

Have you had any of the following tests?

Test	Year	Where was it done?
<input type="checkbox"/> X-ray	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> CT	_____	_____
<input type="checkbox"/> EMG	_____	_____

List All Drug Allergies:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Medications

List all current medications:

<u>Medication</u>	<u>Dose</u>	<u>Actual # taking/day</u>	<u>Does it help?</u>	
_____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Past Medical History

List all current medical problems: _____

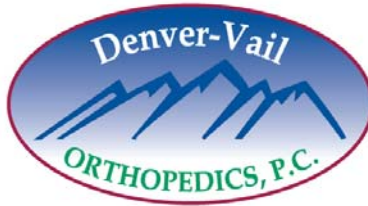
Past Surgical History

List all previous surgeries and hospitalizations

Date	Surgery
_____	_____
_____	_____
_____	_____

Have you ever had problems with anesthesia? Yes No

Explain _____



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Social History

Marital Status: Single Married Divorced Separated Widowed

Do you live alone? Yes No

Do you have children? Yes # _____ No

Do you smoke? Yes No If yes, ___ packs per day for ___ years?

Have you quit smoking? Yes No If yes, When? _____

Previously smoked ___ packs per day for ___ years?

Do you chew tobacco? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, ___ drinks per week?

History of substance abuse? Yes No If yes, describe _____

Occupation: _____ Employer: _____

How long have you been at this job? _____

- Work Status? This problem has not affected my work
- Working ___% less because of this problem
- Unable to work for ___ weeks/months because of this problem

Is this a worker's compensation injury? Yes No

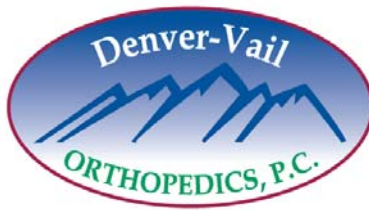
Is this injury the result of an automobile accident? Yes No

Is there an attorney involved with this injury? Yes No

Family History

Have any of your grandparents, parents, siblings, or children had the following conditions? Please explain.

- Diabetes Yes No _____
- Muscular Dystrophy Yes No _____
- Rheumatoid Arthritis Yes No _____
- Scoliosis Yes No _____
- Dwarfism Yes No _____



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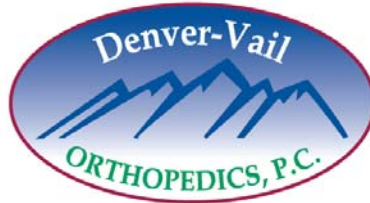
Review of Systems

Are you currently or have you had problems in the past with your:

	Check one	Describe all yes responses
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ears, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lungs/Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Digestion/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bowel movement	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart problems/Chest pain (including rheumatic fever)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding problems/blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Balance problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Numbness/Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blackouts/Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Migraines/Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychological problems/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
AIDS/Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Muscular Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis/Rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Recent Fevers/Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Recent Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	Explain	_____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____



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Resources for Smoking Cessation

We at Denver Vail Orthopedics, P.C. recognize the difficulties associated with quitting smoking, and also the importance to your spine and overall health in doing so. Most people are aware of the effects that smoking has on the heart, blood vessels and lungs, but few know of the impact on the spine.

Smoking can lead to degenerative disc disease and inhibit healing after spine surgery, especially if a fusion is required.

Below we have provided a few informational sources to help get you started with this process. It is important that you work with your primary physician on your road to better health.

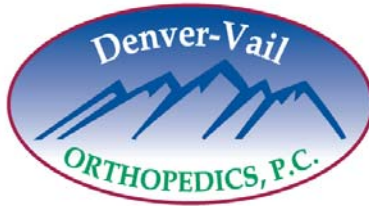
This is a comprehensive website for clinicians **and** those wishing to quit: http://www.cdc.gov/tobacco/quit_smoking/index.htm

Another comprehensive site with medical information and multiple links: <http://www.nlm.nih.gov/medlineplus/smokingcessation.html>

This is a sponsored site with helpful tips and information:
<http://www.smoking-cessation.org/index.asp>

This site provides information on Chantix, one of many medication options, which you will need to discuss with your primary physician:
<http://www.chantix.com/>

If you need financial assistance: 1-800-quitnow (1-800-784-8669)
www.co.quitnet.com



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Notice to Patients Regarding Disability Paperwork:

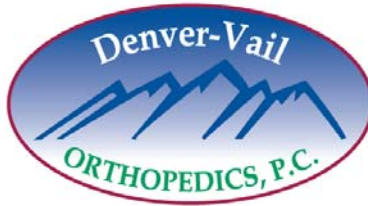
Dr. Stanley and his staff will be happy to complete disability paperwork for you. However, there will be a \$25.00 fee assessed for this service.

This fee does not apply to FMLA paperwork.

Thank you.

Patient Name: _____

Patient Signature: _____ Date: _____



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Post-Operative Instructions After Cervical Spine Surgery

We want to make this experience as pleasant as possible for you and your family. Please contact us if you have any questions before or after your surgery.

Post-Operative Discomfort

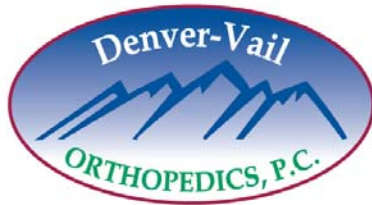
It is not unusual to experience the following symptoms in the first few weeks after surgery:

- Discomfort in and around the incision(s) with mild swelling or redness
- Some persistent neck or shoulder discomfort
- Discomfort on moving from bed to chair or standing position. It is not unusual to be uncomfortable during the first few days following surgery, and especially at night. This will improve steadily.
- A sore throat when you swallow. If you have been given a Medrol Dose pack, continue to take this medication as prescribed.

Pain Medication

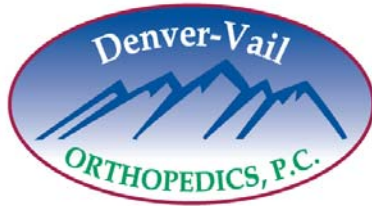
You will be given a prescription for pain medicine when you are discharged from the hospital. You may also get a prescription for a muscle relaxant. Take them as needed and directed.

- No prescription refills will be called in at night or on weekends.
- Do **not** begin taking Non-Steroidal Anti-Inflammatory Drugs or NSAIDs (Advil, Motrin, Ibuprofen, Nuprin, Aleve, etc.) until approximately 3 months after surgery.
- You may be prescribed a Medrol Dose pack (a steroid) to take after you are home from the hospital. Take this prescription as directed. You must take the entire prescription. This may cause you to feel nervous or jittery. It may also cause difficulty sleeping. These symptoms will improve once you have finished your prescription.



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- ✓ Wear your collar at all times unless otherwise directed by Dr. Stanley. You may remove it to shower, wash, shave, etc. Move your body as a unit while limiting excessive neck motions. Avoid big 'yes' or 'no' motions with your head. The collar is not there to restrict all neck movement. It is there to restrict **excessive** movement to allow a smooth recovery.
- ✓ You will wear a hard cervical collar for approximately 2-4 weeks after your surgery. This may vary on a case by case basis. You must wear your brace at all times, with the exception of showering or while seated in a chair.
- ✓ Decisions regarding returning to work and physical therapy needs will be made on an individual basis by our medical staff.
- ✓ The pain medication and anesthesia can cause problems with constipation. Start a stool softener daily, increase fluids, and walk as tolerated to help with constipation. It is okay to use an over the counter suppository (such as Dulcolax) or an oral laxative (such as Dulcolax tabs or Milk of Magnesia), as needed, if you have had no bowel movement by 3 days after your surgery.
- ✓ It is okay to sleep on your side, back, or in a reclining position. Keep your head in a neutral position
- ✓ Sexual activity is permitted whenever comfort allows.
- ✗ You should **not** drive until the cervical collar is removed by Dr. Stanley or until he or his staff instruct you otherwise. You may ride in a car as a passenger. Minimize long trips for a week or two.
- ✗ **Do not** use time at home as an excuse to do physically demanding work.
- ✗ **Do not** remain confined to bed during the day. Walk as much as you comfortably can. You may climb stairs.
- ✗ **Avoid** exaggerated bending or twisting or lifting more than 20 lbs for three months after surgery. No overhead lifting, and excessive flexion or extension of the neck for 3 months.
- ✗ **No** exercise program until you are released by your doctor to do so.



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Calling the Office

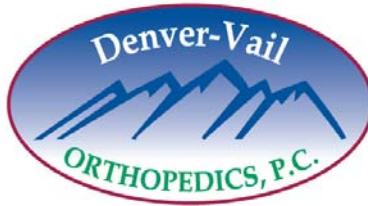
We are here to help you. Please call with any questions. Our Medical Assistant or Nurse Practitioner will call you during the first week after discharge from the hospital to check on your progress. Notify the office if your phone number differs from the one you gave us at your initial visit. **Call our office at 303-214-4500 if any of the following occur:**

- Sustained fever greater than 101.5 degrees Fahrenheit by mouth that does not respond to a dose of two tablets of Tylenol. (Do not take Tylenol if you have any contraindications or allergies to Tylenol.)
- Drainage from the incision(s) (spotty drainage may be normal for the first few days)
- Incision is very red or warm to the touch.
- Arm or neck pain or swelling in excess of your pre-operative pain.
- Difficulty swallowing, that is getting worse on a daily basis
- New onset leg pain, specifically if accompanied by calf swelling and redness

Calling 911

Call 911 immediately if any of the following occur:

- Difficulty breathing, shortness of breath or pain with breathing
- Chest pain
- Loss of Bowel or Bladder control



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Post-Operative Instructions After Lumbar Spine Surgery

We want to make this experience as pleasant as possible for you and your family. Please contact us if you have any questions before or after your surgery.

Post-Operative Discomfort

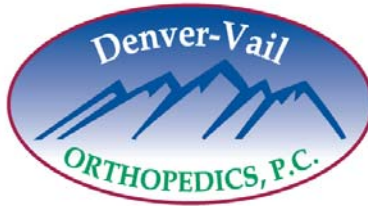
It is not unusual to experience the following symptoms in the first few weeks after surgery:

- Discomfort in and around the incision(s) with mild swelling or redness
- Some persistent leg discomfort
- Numbness or tingling of the leg or foot
- Muscle tightness or spasm of the back or leg
- Discomfort on moving from bed to chair or standing position. It is not unusual to be uncomfortable during the first few days following surgery, and especially at night. This will improve steadily.

Pain Medication

You will be given a prescription for pain medicine when you are discharged from the hospital. You may also get a prescription for a muscle relaxant. Take them as needed and directed.

- No prescription refills will be called in at night or on weekends.
- Do **not** begin taking Non-Steroidal Anti-Inflammatory Drugs or NSAIDs (Advil, Motrin, Ibuprofen, Nuprin, Aleve, etc.) until approximately 3 months after surgery.
- You may be prescribed a Medrol Dose pack (a steroid) to take after you are home from the hospital. Take this prescription as directed. You must take the entire prescription. This may cause you to feel nervous or jittery. It may also cause difficulty sleeping. These symptoms will improve once you have finished your prescription.



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Incision Care

There will be either staples OR sutures & paper band aids (steri-strips) holding the incision closed.

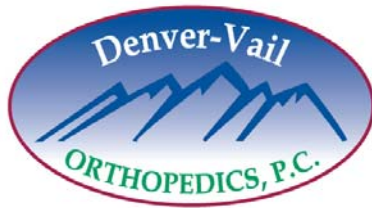
- Change the dressing(s) daily for the first 48 hours after surgery with gauze sponges and tape, or when the dressing is soiled. After that, if there is no drainage, you may cover with an oversized Band-Aid or gauze sponges and tape as needed. Redness and/or persistent or purulent drainage should be reported to our office.
- You may shower 48 hours after surgery. Water will not hurt the incision but do **not** tub bathe or soak the wound.
- Do **not** apply ointments or solutions to the incision. Mild soap and water is okay.
- If you develop blisters, redness, or irritation from the tape, discontinue its use.

Do's and Don'ts

You should think of the first week after surgery as an extension of your hospital stay. In general, if any activity increases discomfort, don't do it.

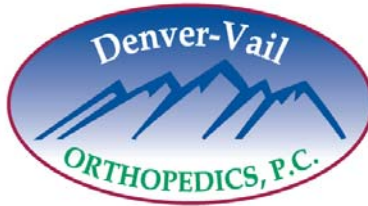
Your first post op visit will be scheduled 10-14 days after surgery. The Assistants will change the bandage, remove sutures/staples and evaluate the incision. An x-ray will often be ordered on the day of your second post-op visit (usually at about 1 month post-op) if you have had a lumbar fusion.

- ✓ If you have had a lumbar fusion, you may wear a brace or corset for one month. Microdiscectomy patients will wear a lumbar corset for 2 weeks. This may vary on a case by case basis. You must wear your brace at all times, with the exception of showering, sleeping and sitting in a chair. You will then wean out of your brace, wearing it for comfort, especially with activity.



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- ✓ Move your body as a unit while limiting bending, lifting, and twisting motions (The “BLTs”).
- ✓ You may drive following surgery when you feel comfortable. **Avoid** driving while taking narcotic pain medications. You may ride in a car as a passenger. Try to limit long trips for a few weeks, but if necessary, get out and walk around hourly to minimize discomfort.
- ✓ It is okay to sleep on your side, back, or in a reclining position. Keep your head in a neutral position, and use the log-roll technique when getting into and out of bed to avoid excessive twisting and bending.
- ✓ Decisions regarding returning to work and physical therapy needs will be made on an individual basis by our medical staff.
- ✓ The pain medication and anesthesia can cause problems with constipation. Start a stool softener daily, increase fluids, and walk as tolerated to help with constipation. It is okay to use an over the counter suppository (such as Dulcolax) or an oral laxative (such as Dulcolax tabs or Milk of Magnesia), as needed, if you have had no bowel movement by 3 days after your surgery.
- ✓ Sexual activity is permitted whenever comfort allows.
- ✓ If you have had a lumbar fusion, a doctor’s note may be required by your airline before they allow you to clear security.
- X **Do not** use time at home as an excuse to do physically demanding work.
- X **Do not** remain confined to bed during the day. Walk as much as you comfortably can. A reasonable goal is to walk a total of 2 miles in a day at 2 weeks after surgery. You may climb stairs.
- X **Avoid** exaggerated bending lifting or twisting. You may bend 30 degrees forward at the waist and twist as required to get into your automobile. No lifting of anything heavier than 20 lbs for 3 months after surgery.
- X **No** exercise program until you are released by your doctor to do so.
- X Hot tubs – Patients **should not** use a hot tub for at least 1 month post op.



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Calling the Office

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- Drainage from the incision(s) (spotty drainage may be normal for the first few days)
- Incision is very red or warm to the touch.
- Leg or back pain or swelling in excess of your pre-operative pain.
- Increased or new onset leg pain, especially when accompanied by calf redness, swelling, or warmth.
- Increased leg weakness.

Calling 911

Call 911 immediately if any of the following occur:

- Difficulty breathing, shortness of breath or pain with breathing
- Chest pain
- Loss of Bowel or Bladder control