

**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](http://www.denvervailorthopedics.com).

Warmest regards,

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

# Denver Vail Orthopedics Patient Information

Page: 1

Patient ID: 1016

## Please Complete Entire Form

Date: 5/26/2011

Time: 4:38 PM

Treating Physician: \_\_\_\_\_ Name: \_\_\_\_\_

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

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address: \_\_\_\_\_ City, St., Zip \_\_\_\_\_

Race: \_\_\_\_\_  Declined Ethnicity: \_\_\_\_\_  Declined Primary Language: \_\_\_\_\_  Declined

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Referring Prov. Ph#: \_\_\_\_\_ Primary Care Prov. Ph#: \_\_\_\_\_

Referring Prov Addr: \_\_\_\_\_ Primary Care Prov. Addr: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Emg/ Contact 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:

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

Policy Holder (If different from Pt) Policy Holder SS#: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

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

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

Policy Holder Address: (If different from pt) Policy Holder SS#: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

#### Please Complete:

Primary Ins: \_\_\_\_\_

Policy ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Site of Injury: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

Policy ID #: \_\_\_\_\_

Group #/ W. Comp. Claim #: \_\_\_\_\_

Adjuster: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

#### HOW WERE YOU REFERRED TO US? \_\_\_\_\_

**Assnment of Benefits:** Please remember that insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment 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 to myself.

Date: \_\_\_\_\_ Signed: X \_\_\_\_\_

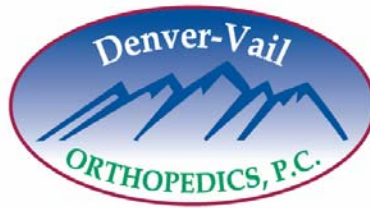
"SIGNATURE ON FILE" will automatically print on your claim, allowing your insurance to pay us directly.

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

Date: \_\_\_\_\_ Signed: X \_\_\_\_\_

**Notice of Privacy:** I have received a copy of the Notice of Privacy Practices from Denver Vail Orthopedics, P.C.

Date: \_\_\_\_\_ Signed: X \_\_\_\_\_



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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.

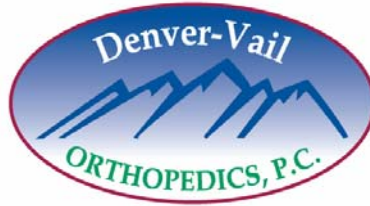
\_\_\_\_ 3. I realize that all medication have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

\_\_\_\_ 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.



**Scott K. Stanley, M.D.**

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

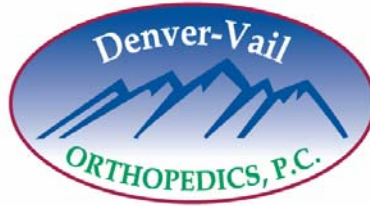
These include ice/heat, massage, deep breathing and relaxation techniques, and use of over-the-counter medications such as Extra Strength Tylenol (check with physician before beginning any over-the-counter medication). I agree that continued prescribing of medications may be contingent upon compliance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



**Scott K. Stanley, M.D.**

\_\_\_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.

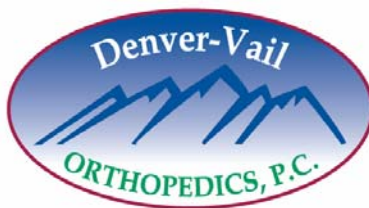
\_\_\_16. **I understand that if am receiving pain medications from multiple doctors, Denver Vail Orthopedics, PC will discontinue prescribing pain medications and I will be dismissed from the practice.**

\_\_\_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.



**Scott K. Stanley, M.D.**

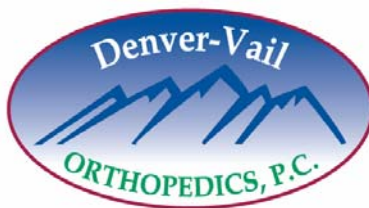
\_\_\_21. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better 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.



**Scott K. Stanley, M.D.**

**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 \_\_\_\_\_

# DENVER-VAIL ORTHOPEDICS, PC

## MEDICAL HISTORY FORM

Please complete both sides and do not use white out

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ PHARM. PHONE \_\_\_\_\_

PHARMACY ADDRESS \_\_\_\_\_ PHARM. FAX \_\_\_\_\_

### PAST MEDICAL HISTORY:

NO MEDICAL PROBLEMS	<b>Y/N</b> HYPERTENSION (HBP)	<b>Y/N</b> THYROID DISORDER
<b>Y/N</b> BLOOD CLOT IN LEG (ACUTE/CHRONIC)	<b>Y/N</b> HEART ATTACK (MI)	<b>Y/N</b> WEIGHT LOSS
<b>Y/N</b> CVA (STROKE) WHEN? _____	<b>Y/N</b> OSTEOARTHRITIS	<b>Y/N</b> CANCER (TYPE _____)
<b>Y/N</b> COPD	<b>Y/N</b> OSTEOPOROSIS	_____
<b>Y/N</b> CORONARY ARTERY DISEASE	<b>Y/N</b> PEPTIC ULCER DISEASE	<b>Y/N</b> BLEEDING DISORDER (TYPE _____)
<b>Y/N</b> CROHN'S DISEASE	<b>Y/N</b> PERIPHERAL NEUROPATHY	_____
<b>Y/N</b> DEPRESSIVE DISORDER	<b>Y/N</b> PERIPHERAL VASCULAR DISEASE	<b>Y/N</b> CLOTTING DISORDER (TYPE _____)
<b>Y/N</b> DIABETES MELLITUS TYPE I	<b>Y/N</b> POLIO	_____
<b>Y/N</b> DIABETES NELLITUS TYPE II	<b>Y/N</b> PULMONARY EMBOLISM	
<b>Y/N</b> GOUT	<b>Y/N</b> REACTION TO ANESTHESIA	
<b>Y/N</b> HEPATITIS	<b>Y/N</b> RHEUMATIOD ARTHRITIS	
<b>Y/N</b> HIV	<b>Y/N</b> SYSTEMIC LUPUS	
<b>Y/N</b> OTHER _____		

### HAVE YOU HAD ANY SURGERIES OR PROCEDURES? Y/N

SURGERY/PROCEDURE	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

### LIST ALL PRESCRIPTIONS, OVER-THE-COUNTER MEDICINES AND SUPPLEMENTS YOU TAKE REGUALRY

MEDICATION	DOSE/FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____

### DO YOU HAVE ANY ALLERGIES TO MEDICATION OR LATEX? Y/N

ALLERGIC TO:	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

### FAMILY HISTORY

#### HAS ANY BLOOD RELATIVE HAD ANY OF THTE FOLLOWING? CHECK ALL THAT APPLY

<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> CHRONIC DVT OF LEG	<input type="checkbox"/> CANCER – TYPE _____
TYPE _____	<input type="checkbox"/> SUDDEN CARDIAC DEATH	<input type="checkbox"/> MUSCULAR DYSTROPHY
<input type="checkbox"/> CLOTTING DISORDER	<input type="checkbox"/> ARTHRITIS (OSTEO OR RHEUMATOID)	<input type="checkbox"/> PULMONARY EMBOLISM
TYPE _____	<input type="checkbox"/> CARDIOVASCULAR DISEASE	<input type="checkbox"/> REACTION TO ANESTHESIA
	<input type="checkbox"/> DIABETES (TYPE I OR TYPE II – CIRCLE)	<input type="checkbox"/> SCOLIOSIS

OTHER/DETAILS FOR ABOVE: \_\_\_\_\_

**SOCIAL HISTORY**

ARE YOU CURRENTLY WORKING? YES NO CURRENT OCCUPATION: \_\_\_\_\_  
MARITAL STATUS (CIRCLE): SINGLE ENGAGED MARRIED DIVORCED SEPARATED WIDOWED I LIVE ALONE PARTNER  
DO YO HAVE CHILDREN? YES- HOW MANY \_\_\_\_\_ NO  
DO YOU SMOKE? YES – HOW MUCH PER DAY? \_\_\_\_\_ NEVER QUIT- WHEN? \_\_\_\_\_  
DO YOU USE SMOKELESS TOBACCO? YES – HOW MUCH PER DAY? \_\_\_\_\_ NEVER QUIT- WHEN? \_\_\_\_\_  
DO YOU DRINK ALCOHOL? YES – HOW MUCH & HOW OFTEN? \_\_\_\_\_ NEVER QUIT- WHEN? \_\_\_\_\_  
DO YOU USE ILLEGAL DRUGS? YES – HOW MUCH & HOW OFTEN? \_\_\_\_\_ NEVER QUIT- WHEN? \_\_\_\_\_  
PRESCRIPTION DRUG ABUSE HISTORY? YES/NO DRUG \_\_\_\_\_  
DO YOU DRINK CAFFEINE? YES/NO – WHAT KIND & HOW OFTEN? \_\_\_\_\_  
HOW MUCH EXERCISE DO YOU GET? SEDENTARY 1 TIME/WEEK 1-3 TIMES/WEEK 4 OR MOR ETIMES/WEEK  
ACTIVE BUT NO FORMAL EXERCISE

**HISTORY OF PRESENT ILLNESS**

WHO REFERRED YOU TO US? \_\_\_\_\_  
WHICH IS YOUR DOMINANT SIDE? (CIRCLE) RIGHT HANDED LEFT HANDED AMBIDEXTROUS  
WHAT ARE YOU BEING SEEN FOR TODAY? \_\_\_\_\_ RIGHT LEFT BOTH  
WHEN DID YOUR SYMPTOMS START? \_\_\_\_\_  
HOW DID YOUR SYMPTONS BEGIN? GRADUALLY SUDDENLY SPECIFIC INJURY  
IS THIS A WORKER’S COMPENSATION INJURY? YES NO IS THIS THE RESULT OF AN AUTOMOBILE ACCIDENT? YES NO  
IS THERE AN ATTORNEY INVOLVED WITH THIS INJURY? YES NO  
PLEASE EXPLAIN WHAT HAPPENED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION? (EX: PHYSICAL THERAPY, INJECTIONS, WHEN? FOR HOW LONG?)

TREATMENT TRIED	MONTH/YEAR	HOW MANY TIMES/WEEKS/MONTHS
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT TREATMENTS HELPED? \_\_\_\_\_

WHAT TESTS HAVE BEEN PERFORMED FOR THIS CONDITION?  
X-RAY WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_  
MRI WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_  
CT WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_  
EMG WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_

HAVE YOU INJURED THIS AREA BEFORE? YES NO DESCRIBE: \_\_\_\_\_

HAVE YOU MISSED TIME AT WORK FOR THIS CONDITION? YES NO COULD YOU BE PREGNANT YES NO

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**REVIEW OF SYSTEMS – DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS?**

- |                          |                                |                                 |
|--------------------------|--------------------------------|---------------------------------|
| <b>Y/N</b> FEVER/CHILLS  | <b>Y/N</b> SHORTNESS OF BREATH | <b>Y/N</b> WEIGHT LOSS          |
| <b>Y/N</b> BLURRY VISION | <b>Y/N</b> NAUSEA              | <b>Y/N</b> ANXIETY              |
| <b>Y/N</b> HEADACHE      | <b>Y/N</b> INCONTINENCE        | <b>Y/N</b> DEPRESSION           |
| <b>Y/N</b> VERTIGO       | <b>Y/N</b> RASH                | <b>Y/N</b> BLOOD CLOTS/BRUISING |
| <b>Y/N</b> CHEST PAIN    | <b>Y/N</b> MUSCLE WEAKNESS     | <b>Y/N</b> FREQUENT ILLNESS     |

**Spine Health History**

Date: / /

Name: \_\_\_\_\_

DOB: / /

Tell us about your symptoms:

How did your symptoms begin?  Gradually  Suddenly  Specific Injury

When did your symptoms begin? \_\_\_\_\_

On a scale of 0 to 10 with 10 being the worst pain, how would you rate your pain? \_\_\_\_\_

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 your symptoms better? \_\_\_\_\_

.....  
Have you had any of the following treatments? Did this treatment help? Dates of treatment?

Physical Therapy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chiropractor:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Massage Therapy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Acupuncture:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
TENS Unit:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Brace:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	_____

Have you had previous neck/back surgery?  Yes  No

Date	Surgery Type	Surgeon
/ /	_____	_____
/ /	_____	_____

Spine Health History

Date: / /

Name: \_\_\_\_\_

DOB: / /

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

Aching \*\*\*

Numbness ===

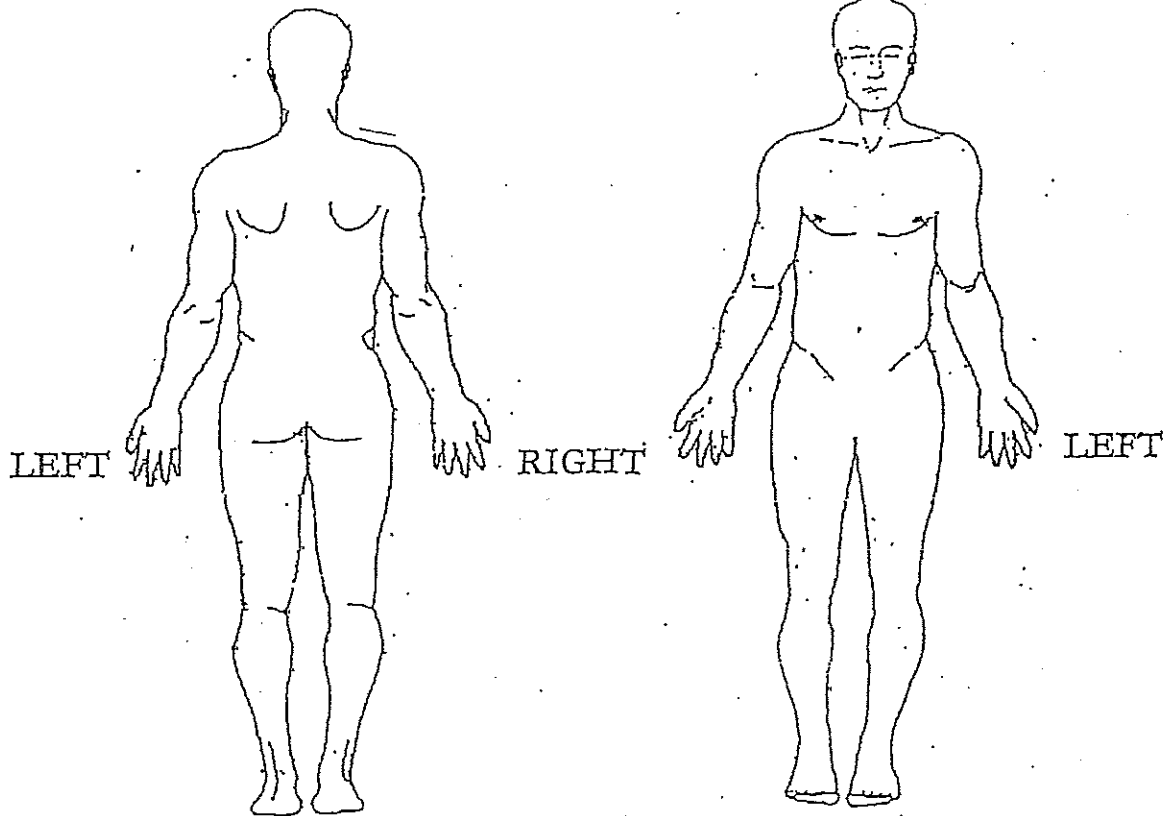
Pins and needles OOO

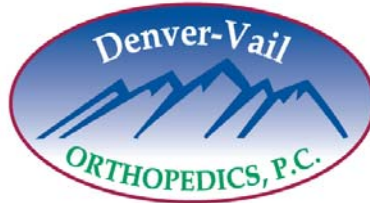
Burning X X X

Stabbing ///

BACK

FRONT





**Scott K. Stanley, M.D.**

## **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.

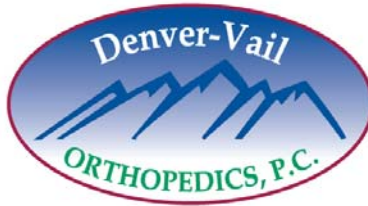
This is a comprehensive website for clinicians **and** those wishing to quit: [http://www.cdc.gov/tobacco/quit\\_smoking/index.htm](http://www.cdc.gov/tobacco/quit_smoking/index.htm)

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](http://www.co.quitnet.com)



**Scott K. Stanley, M.D.**

## **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**

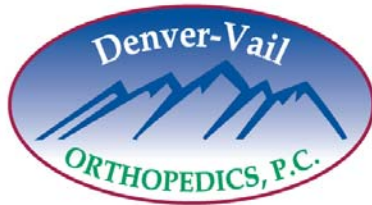
It is not unusual to experience the following symptoms in the first few weeks after surgery:

- 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**

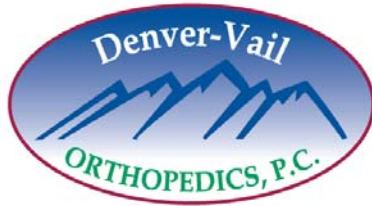
You will be given a prescription for pain medicine when you are discharged from the hospital. You may also get a prescription for a muscle relaxant. Take them as needed and directed.

- 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.



**Scott K. Stanley, M.D.**

- ✓ 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.
- X 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.
- 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. You may climb stairs.
- X **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.
- X **No** exercise program until you are released by your doctor to do so.



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### **Calling the Office**

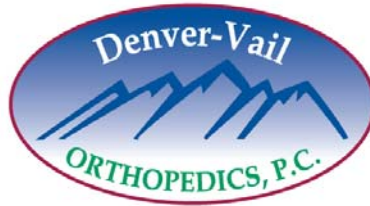
We are here to help you. Please call with any questions. Our Medical Assistant or Nurse Practitioner will call you during the first week after discharge from the hospital to check on your progress. Notify the office if your phone number differs from the one you gave us at your initial visit. **Call our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



**Scott K. Stanley, M.D.**

## **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**

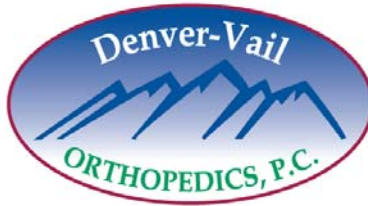
It is not unusual to experience the following symptoms in the first few weeks after surgery:

- 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.

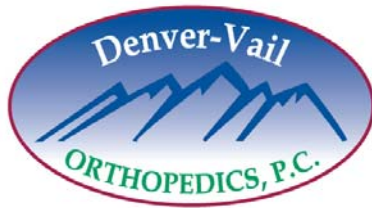
- Change the dressing(s) daily for the first 48 hours after surgery with gauze sponges and tape, or when the dressing is soiled. After that, if there is no drainage, you may cover with an oversized Band-Aid or gauze sponges and tape as needed. Redness and/or persistent or purulent drainage should be 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.

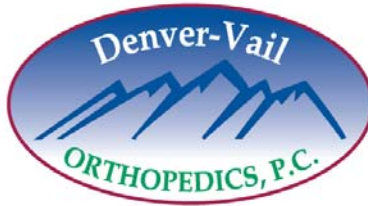
Your first post op visit will be scheduled 10-14 days after surgery. The Assistants will change the bandage, remove sutures/staples and evaluate the incision. An x-ray will often be ordered on the day of your second post-op visit (usually at about 1 month post-op) if you have had a lumbar fusion.

- ✓ 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.



**Scott K. Stanley, M.D.**

- ✓ 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