

**HOME CARE INSTRUCTIONS FOLLOWING
RADIOFREQUENCY ABLATION OF _____**

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Date: _____

ACTIVITY

1. Minimal long-term standing of "right angle" sitting; to be walking or lying down with back flat and leg(s) elevated with heel(s) "in the breeze" and do frequent range of motion of feet.
2. WALK, WALK, WALK!
3. Do not lift more than 20 lbs. for three weeks.
4. No driving for 3-4 days or while taking pain medicine.

SURGICAL SITE CARE

1. Leave dressing on until
Then may remove dressing and get wounds wet in shower, pat dry.
2. Cover wounds with sterile dressing and re-wrap legs from mid forefoot to high thigh with ACE wrap.
3. Leave steri strips on, they usually fall off in 5-7 days.

COMFORT

1. You may need to use prescription pain medicine regularly at first and then only as needed. If pain medication does not keep you comfortable, contact your doctor. If nausea occurs, take food in 1/2 hour prior to taking medication. If nausea persists or rash occurs, stop taking medication and call your doctor.
2. For milder discomfort, use over-the-counter pain medication.

NEW MEDICATIONS

1. New medications:

2. Last dose of pain medication:

DIET

Some of the sedative/anesthetic medication you received today may make you nauseated. Begin with clear liquids and then progress to solid foods as your stomach tolerates them.

If you become nauseated, tea or carbonated beverages are helpful. If **vomiting** persists, call your doctor.

SAFETY

1. You can expect to feel dizzy, weak and drowsy for as long as:
 - 24 hours after receiving a general anesthetic
 - 12 hours after receiving sedation
 - while taking prescription pain medication



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2. Please follow these instructions for that time:
 - a. **DO NOT** drive a car or operate machinery.
Your reflexes and coordination are not up to normal. Have standby assistance on stairways.
 - b. No alcoholic beverages today.
 - c. Postpone signing any important papers or making any important decisions.
3. Because of the effects of anesthesia/sedation, we recommend that you have someone stay with you for 12-24 hours or overnight following your procedure.

RETURN APPOINTMENT

DR: _____

DATE/TIME: _____

WHEN TO CALL

If any of the following symptoms occur: **ABNORMAL OR DECREASE IN CIRCULATION TO LOWER EXTREMITY** (i.e., numbness, coolness, grey/blue color), **REDNESS AROUND THE INCISION(S)**, **DRAINAGE**, **SEVERE PAIN**, **FEVER OVER 101°**, **PERSISTENT NAUSEA AND VOMITING**, **RASH OR ANY CONCERNS ABOUT YOUR RECOVERY**.

A nurse will attempt to call you in the next few days to discuss your recovery and any questions or concerns you may have. If you have a question or concern before you hear from us, please don't hesitate to call. In case of emergency, please go to your nearest emergency facility.

WHO TO CALL

DR. _____

PHONE: _____

AFTER HOURS:

Aspirus Day Surgery Plus - Open 6:00 a.m.-7:00 p.m.

Phone: 847-2907 Monday - Friday

I have discussed the above information with a nurse and my questions have been answered to my satisfaction.

Patient or Responsible Party Signature

Date/Time

RN Signature

Date/Time