



Place Patient Sticker Here

**ORTHOPEDIC
DISCHARGE INSTRUCTIONS**

Ht: _____ cm

Wt.: _____ kg

Allergies: _____

DATE & TIME	PHYSICIAN'S ORDERS AND DIET	DATE & TIME	PROGRESS RECORD
	1. <input type="checkbox"/> Keep affected extremity elevated at all times.		Note Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, Instructions to Patient.
	2. <input type="checkbox"/> Apply ice intermittently for <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours		
	3. <input type="checkbox"/> Observe the affected extremity for circulation or nerve impairment.: Change in color, coldness, numbness, or tingling, increased pain. If any of these are present, call your physician.		
	4. Dressing: <input type="checkbox"/> Keep dressing clean and dry.		
	<input type="checkbox"/> Do not remove dressing		
	<input type="checkbox"/> Reinforce dressing as needed		
	<input type="checkbox"/> Change dressing: <input type="checkbox"/> 24 hours after surgery		
	<input type="checkbox"/> 48 hours after surgery <input type="checkbox"/> 1 week after surgery		
	5. Weight bearing: <input type="checkbox"/> Non WB <input type="checkbox"/> WB to tolerance		
	<input type="checkbox"/> Touch WB		
	6. DME: <input type="checkbox"/> Crutches <input type="checkbox"/> Knee Immobilizer <input type="checkbox"/> Walker		
	<input type="checkbox"/> Cane <input type="checkbox"/> Walking Boot		
	<input type="checkbox"/> CPM at <input type="checkbox"/> 30° <input type="checkbox"/> 45°		
	7. Do ankle pump exercises 20 repetitions:		
	<input type="checkbox"/> 2 times daily <input type="checkbox"/> 3 times daily		
	8. <input type="checkbox"/> No Tub Bath <input type="checkbox"/> Tub Bath <input type="checkbox"/> Shower		
	9. <input type="checkbox"/> Notify MD's Office:		
	MD- phone number		
	If you have a temperature at 39°C (102°F) or higher		
	If you have pain that your medicines don't help		
	If you have an increase in drainage		
	If you have any problems or questions		
	10. Make an appointment to see your MD in <input type="checkbox"/> 1 week		
	<input type="checkbox"/> 2 weeks		
	11. Discharge when stable		
	Physician Signature: _____		
	Physician ID#: _____		
	Nurse: _____		