Name

Room No.

Hosp. No.

Physician

INSTRUCTIONS FOR POST HOSPITAL CARE

FOR _____

MEDICATIONS

MEDICINE	DOSE/FREQUENCY	SPECIAL INSTRUCTIONS

DIET

☐ No Restrictions ☐ Restricted to: _____

Suggested Food/Fluids: _____

Avoid: _____

Special Instructions: _____

ACTIVITIES

☐ Complete Bed Rest ☐ Up for Meals/Bathroom Only ☐ Up as Desired

BATH: ☐ Sponge ☐ Tub ☐ Shower

HOUSEHOLD DUTIES: ☐ Light (Dishes, Dusting) ☐ Moderate (Laundry, Vacuuming) ☐ Unrestricted

EXERCISE: ☐ Light (Short distance walking) ☐ Moderate (Driving, walking) ☐ Unrestricted (Lifting, jogging)

Suggested Activities: _____

Avoid: _____

Special Instructions: _____

WOUND CARE

_____

OTHER INSTRUCTIONS

_____

FOLLOW-UP CARE

☐ A follow-up appointment has been scheduled for you with Dr. _____

on _____ (Day) _____ (Date) at _____ a.m./p.m.

☐ Please schedule a follow-up appointment with Dr. _____

in _____ days/weeks/months.

THE POST HOSPITAL CARE INSTRUCTIONS SET FORTH ABOVE HAVE BEEN EXPLAINED TO ME. I UNDERSTAND ALL INSTRUCTIONS AND THE IMPORTANCE OF FOLLOWING THEM AS SPECIFIED.

_____ _____

Patient/Responsible Person Signature Date

_____ _____

Physician/Nurse Signature Date

Form 1253/2 BRIGGS, Des Moines, IA 50306 (800) 247-2343 6/90
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