



Valley Pain Center
Masons Mill Park II
1800 Byberry Road, Suite 1101
Huntingdon Valley, PA 19006
phone: 215-947-7992 | fax: 215-947-7969
www.ValleyPainCenter.com

Discharge Instructions

All Patients:

- You may experience an increase in your symptoms for the first 2 days (It can take 2 days - 2 weeks for the steroid to work).
- You may apply ice to the site for the first 24 - 36 hours, 20 minutes each hour.
- You may take your pain medicine
- You may resume your regular medication
- You may shower, no swimming, tub bath or Jacuzzi for 24 hours.
- You may resume light activities, as tolerated. check with your referring physician about re-starting Physical Therapy.
- **RFL patients - You may experience pain at the site and skin sensitivity for 2 weeks.**

If you have had IV sedation the following should be followed. If your procedure was completed with local anesthesia, please disregard.

- Do not drive for 24 hours
- Do not use public transportation unaccompanied for 24 hours
- Do not operate hazardous machinery for 24 hours
- Do not make important personal/business decisions for 24 hours
- Initially resume a light diet and advance as tolerated

Possible Procedure Side Effects

Increased Pain	Increased numbness/tingling	Headache
Nausea/Vomiting	Hematoma (bruising/bleeding at the site)	Edema (swelling at the site)
Difficulty with movement/ambulation		Infection (redness, drainage at site)

Possible Steroid Side Effects

Change in menstrual flow	Edema (swelling)	Increased appetite
Skin flushing (redness)	Skin rash/acne	Thrush (oral)
Vaginitis	Sweats	Depression
Increased blood glucose (sugar) levels	Euphoria (feeling happy)	

If you have any questions feel free to call us at 215-947-7992. If you experience any problems after business hours (7:30 am - 4:00 pm), please call your referring physician at _____

Your next scheduled appointment for _____ is _____
Follow up with your referring physician, Dr. _____

THESE INSTRUCTIONS HAVE BEEN EXPLAINED TO, AND UNDERSTANDING VERBALIZED BY THE UNDERSIGNED. A COPY OF THE INSTRUCTIONS HAS BEEN GIVEN TO THE UNDERSIGNED. (If patient is not sufficiently alert mentally to make decisions or to understand these discharge instructions, this form should be executed by patient's representative.)

Nurse's Signature _____ Name of Patient _____

By Patient's Representative _____ Signature of Patient _____

Relationship to Patient _____ Date: _____