

RESTORATIVE SPINE AND BRAIN CENTER OF DALLAS

SPINE SURGERY PACKET

Your choice for spine surgery is a decision that should greatly improve the quality of your life. The treatment team with Restorative Spine and Brain Center of Dallas will help you through this process to recovery and better function of life.

The spine team includes your surgeon, anesthesiologist, primary care physician, nursing, physical therapy, social workers, nutritionists, case managers, and pharmacists.

Our goal is to return you to a high level of function so that you may safely return home after a short hospital stay, usually 2 to 3 days, if not an outpatient surgery. While this may sound fast, your recuperation from surgery will occur rapidly. Our knowledge, experience, and technology will provide the basis for success, but YOU will play the most important role. Your active participation and positive attitude, along with your cooperation in following our instructions will help ensure your satisfaction with your spine surgery.

This guide will help you prepare for your spine surgery. Please take the time to review this information with your family to be better prepared.

GETTING TO KNOW YOUR TREATMENT TEAM

Spine surgery requires a team, based approach to ensure the most optimal outcome and reduction of all potential risks. You should become familiar with all of the players.

Surgeon – This is the doctor who performs the actual spine surgery and is responsible for your health during your hospital stay and following your surgery.

Anesthesiologist – Your anesthesiologist is the doctor who administers medications to put you to sleep during your surgery and monitors your vital signs during and after the surgery.

Primary Care Physician – Your primary care physician, or family practitioner, takes care of your health. He or she may perform your pre-operative physical.

Nurse – Before and during your hospital stay, you will encounter several nurses who perform different jobs. Some assist in navigating your progression through the process. Some attend to your daily healthcare needs in the hospital, assist surgeons in the operating room and, in some cases, visit patients at home. Nurses are among the most visible healthcare professionals in the hospital.

Physical Therapist – Your physical therapist is trained to assist you in regaining your mobility. A physical therapist may work with you during your hospital stay and per your doctor's orders after you return home, if needed.

Occupational Therapist – Your occupational therapist is trained to teach you how to perform activities of daily living, such as dressing and bathing after your surgery, if needed.

Case manager – Your case manager oversees coordinating your hospital discharge.

UNDERSTANDING YOUR SPINE

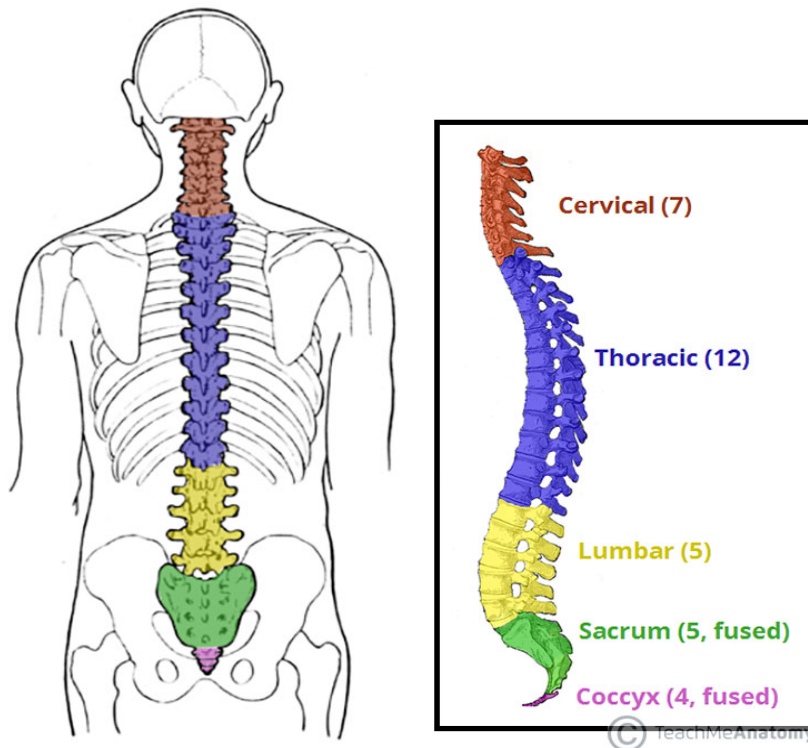
While many spine conditions can be successfully treated with non-surgical methods, some cannot. Now that you and your surgeon have decided surgery is the best option for your condition, it will be especially helpful to have an in-depth understanding of your spine. These diagrams may help you understand some of the terms you may encounter by your treatment team.

SPINE 101: SPINAL ANATOMY

The function of the spine (sometimes call the vertebral column or spinal column) is to protect and support the spinal cord, nerve roots, and internal organs. The spine provides a base of attachment for discs, spinal ligaments, tendons and muscles. The spinal column connects the upper and lower body, provides structural support, aids in balance, and helps distribute weight. The structural elements permit forward and backward bending, spinal rotation and combined movements within normal limits.

The spinal or vertebral column consists of 33 bony vertebrae.

The regions or levels of the spine are known as the cervical (neck), thoracic (upper/middle back), lumbar (lower back), sacral (pelvic area) and coccyx (tailbone).



CERVICAL SPINE

The neck region is the cervical spine. This region consists of seven vertebrae, abbreviated C1 through C7 (top to bottom). These vertebrae protect the brainstem and spinal cord, support the skull and allow a wide range of head movement.

THORACIC SPINE

Below the cervical spine are 12 thoracic vertebrae, abbreviated T1-T12 (top to bottom). T1 is the smallest and T12 is the largest. The thoracic vertebrae are larger than the cervical vertebrae and have longer spinous processes. Rib attachments add to the thoracic spine's strength and stability.

LUMBAR SPINE

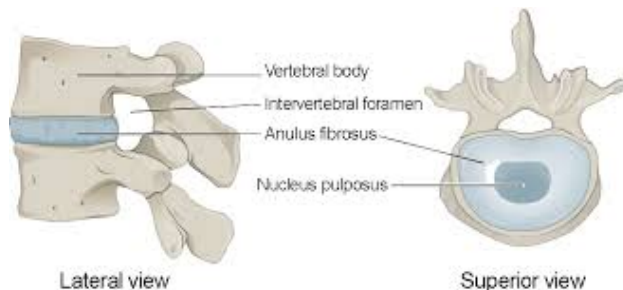
The lumbar spine consists of five vertebrae, abbreviated L1-L5. The lumbar vertebrae are the largest in the spine and carry most of the body's weight. This region allows more range of motion than the thoracic spine, but less than the cervical spine.

SACRUM

The sacrum is located behind the pelvis. Five bones, abbreviated S1-S5, fused into a triangular shape, form the sacrum. The sacrum fits between the two hip bones connecting the spine to the pelvis. The last lumbar vertebra (L5) articulates (moves) with the sacrum. Immediately below the sacrum are five additional bones, fused together to form the coccyx (tailbone).

VERTEBRE

Each spinal vertebrae is composed of many different bony structures. The vertebral body is the largest part of a vertebra.



INTERVERTEBRAL DISC

Intervertebral discs provide cushioning between the spine's vertebral bodies (except for the first two cervical vertebrae). Comprised of fibrocartilaginous material, each normal sturdy intervertebral disc effectively absorbs and distributes the spinal stress you have a rest and while you're moving. Each disc is made up of two parts: the annulus fibrosus and the nucleus pulposus. The annulus fibrosus is a sturdy tire-like outer structure that encases a gel-like center, the nucleus pulposus.

MUSCLES, TENDONS, AND LIGAMENTS

Spinal muscles, tendons and ligaments work together to keep the spine stable at rest and during the activity. The muscles contract to cause the body to move. Tendons connect the spinal musculature to the spine. Tendons are sturdy bands of fibrous connective tissue. Spinal

ligaments are non-elastic fibrous bands or sheets of connective tissue that hold the bones together. Ligaments limit motion and, if overstretched can contribute to joint instability.

SPINAL DISORDERS

HERNIATED DISC

A disc herniation occurs when the outer wall of the disc (annulus fibrosus) tears, breaks open or ruptures. Some of the matter inside the disc (nucleus pulposus) leaks out and compresses nearby spinal nerves and/or the spinal cord. Although a disc herniation can occur at any level of the spine, the lumbar spine (lower back) and cervical spine (neck) are the most common locations affected.

The location of the herniated disc determines where the symptoms are experienced in the body. Symptoms such as numbness and tingling, pain and/or muscle weakness may be experienced in the arm(s) or leg(s) as a result of a herniated disc.

DEGENERATIVE DISC DISEASE

This spinal condition comes from the normal wear and-tear process of aging. As we age, our discs lose some of their flexibility, elasticity and shock absorbing ability. Degenerative disc disease may become problematic if the disc height is reduced or if the disc becomes thin and stiffen.

SPINAL STENOSIS

Spinal stenosis is a condition characterized by the progressive narrowing of one or more areas of the spine. Spinal stenosis can result in the compression of the spinal nerves and spinal cord. Although spinal stenosis can occur anywhere in the spine, the cervical and lumbar areas are most often affected. This condition can lead to the development of pain, numbness, weakness in the arms and/or legs or balance disturbances.

SPONDYLOSIS

Spondylosis is arthritis of the spine, and is often called spinal osteoarthritis. Spondylosis can occur in the cervical, thoracic or lumbar spine. As with other joints in the body, osteoarthritis causes progressive degeneration of cartilage. Some patients are asymptomatic (have no symptoms) and learn they have spondylosis as a result of X-ray or examination for another problem.

SPONDYLOLISTHESIS

Spondylolisthesis comes from the Greek words spondylo, meaning vertebrae, and listhesis, meaning slipping or sliding. Spondylolisthesis is a spinal condition in which one vertebra slips forward over the vertebra below. This disorder most commonly occurs in the lumbar spine. Although spondylolisthesis can cause spinal instability, not all patients experience pain.

RADICULOPATHY

Radiculopathy is not a disease itself, but the result of direct pressure or compression on a nerve root due to a herniated disc or degenerative changes. The nerve roots are branches of the spinal cord that carry signals to the rest of the body at each level along the spine. The location of the radicular symptoms depends on the area supplied by the specific nerve root that is compressed.

MYELOPATHY

Myelopathy is a term used to describe a disease or disorder of the spinal cord (for example, spinal cord compression). Myelopathy can occur at any age and is often due to the compression of the spinal cord by bone or disc material in the cervical spine.

BEFORE YOUR HOSPITAL ADMISSION

This section contains information to help you prepare for your procedure and, if admitted, your hospitalization.

SPINE SURGERY

Most patients elect to proceed with spine surgery after:

- Pain and/or weakness becomes disabling and interferes with daily activity
- Development of bowel and bladder dysfunction
- Conservative treatments, physical therapy, pain management and other treatments have failed

POTENTIAL RISKS OF SPINAL SURGERY

Though every effort is made to ensure your safety is made, there are potential risks associated with any surgical procedure. It is important that you understand the surgical risks in order to make informed decisions about your desire for surgery. Your surgeon will explain these potential risks and will answer your questions.

SURGICAL RISKS

- Bleeding (which could result in the need for a blood transfusion)
- Surgical site infections
- Death
- Injury to the nervous system resulting in worsening pain, weakness, and/or paralysis
- Dural or spinal lining tear may occur resulting in a leak of spinal fluid (in most cases this is repaired during surgery and could require 1-2 days of laying flat in bed)
- The potential that if a fusion is performed you develop a pseudoarthrosis (failure of the fusion to occur)
- Further degenerative changes or acceleration of adjacent segments resulting in the need for further spine surgeries in the future

Myocardial infarction
Pulmonary embolus
Upper extremity or lower extremity DVT
Severe/intractable pain or headache
New paresthesias
Abnormal discharge or drainage from operative site
Bone graft failure
Airway complication (higher incidence in cervical spine procedures)
Dysphagia (anterior cervical spine procedures)
Cerebral spinal fluid leak
Hardware failures
Pulmonary complications
Vertebral fractures
Hematoma formation
Recurrent disc herniation
Mislocated instrumentation
Very rarely, blindness following a prolonged thoracolumbar spine surgery in the face down position may occur

Anesthesia is used during the surgery and places increased stress on your body. A thorough medical evaluation before surgery minimizes the risks. Though extremely rare, anesthesia does have risks.

ANESTHESIA RISKS

Hear attack
Stroke
Death
Corneal abrasion

BEFORE YOUR PROCEDURE / HOSPITAL ADMISSION

VERIFY INSURANCE COVERAGE

If you have health insurance, both the hospital and the surgeon's office will need to contact your insurance company before surgery to verify our coverage. However, we strongly recommend that you also contact your insurance company to verify your benefits. The following is a list of questions to ask your insurance provider before your surgery:

Does my hospital stay need to be pre-approved? If yes, who should pre-approve my hospital stay?

What do I need to do to receive pre-approval?

How many days in the hospital have been approved?

Will additional hospital days be covered if there are complications?
If yes, how many extra days are allowed?
What is my out-of-pocket maximum?
What is my policy's lifetime maximum?
Is a second opinion required?
If I can't return to my prior living arrangements immediately upon discharge, do I have benefits for rehabilitation and physical therapy?

PRE-REGISTRATION AND ADMISSIONS TESTING

Once your surgery is scheduled, a staff member from our office will arrange an appointment for you to visit PAT. This appointment is usually no more than 7 days before your surgery. At the appointment, the PAT staff will conduct an assessment and obtain any tests that may be needed prior to your surgery. These tests include a complete blood count, coagulation profile, comprehensive metabolic panel, urine analysis, pregnancy test (if of child bearing potential), electrocardiogram, and chest x-ray. Other potential labs include nicotine level, hemoglobin A1C if diabetic. The PAT staff will take all your information and compile your medical record in advance of your surgery. Your medical record will be available for members of the surgical team, including the anesthesiologist, to review prior to your surgery. The PAT staff will also give you any instructions you need regarding eating, drinking, and taking medicine immediately before your surgery.

You may also be scheduled for cardiac clearance if you have a significant cardiac history. You may contact the office or hospital if you need more information about the PAT.

ADVANCED DIRECTIVES

All hospitals are legally required to provide information on advanced directives to every patient. Advanced directives are legal documents containing information about your healthcare decisions. If you already have advanced directives, please bring a copy to the hospital.

OTHER THINGS TO DO TO PREPARE FOR YOUR SURGERY

SMOKING

Smoking is detrimental to your health, especially during and after spine surgery. Smokers are at greater risk for lung and heart complications during surgery. After surgery, smokers have a higher likelihood of incomplete or delayed healing of spinal fusions. Nicotine is the culprit of the risk of non union and any use of nicotine by any route (gum, patches, smoking tobacco, and smokeless tobacco). All nicotine products should be stopped prior to surgery and for at least 3 months after surgery. The risk of the bone not healing, resulting in a failure of the fusion, can be increased by more than 40% with the use of nicotine products.

MEDICATIONS

It is important that your treatment team be aware of the medications you take. This includes over-the-counter medications and herbal supplements. Many herbal supplements can affect anesthesia, so please be sure to discuss this at your PAT visit.

Do not take aspirin, ibuprofen, or other anti-inflammatory medications 7 days prior to your surgery unless directed by your physician. This is due to the anti-clotting effects of these medications. Patients undergoing a fusion will need to remain off these medications for 3 months post-operatively due to the risks of the bone failing to fuse.

If you take other blood thinning medications, such as Coumadin (Warfarin), Lovenox, Plavix, Eliquis or Xarelto, speak with your surgeon as to when to stop taking these prior to surgery.

PREPARING YOUR HOME FOR A SAFE RETURN HOME

Preparing your home ahead of time will help make your recovery easier.

BEFORE SURGERY

Arrange for a family member, friend or spine coach to be with you for several days after you return home. This is very important as you will need help mobilizing, caring for yourself and performing household tasks.

Make sure your family and friends will not be on vacation or unavailable on the days following your discharge from the hospital.

Remove throw rugs and other potential obstacles from the floor. These can cause you to slip or fall.

Put frequently used items such as bath towels, dishes and other day-to-day items where they can be easily reaching. Remember that it may be painful and unsafe to bend down or reach up. Consider preparing and freezing meals in advance so they can be easily re-heated. You may not feel like cooking or cleaning for several days after your procedure.

After surgery, you might find it easier to sit in a recliner. It will be more difficult to get up from low furniture than from furniture that sits higher.

Consider arranging for help with yard work, laundry, grocery shopping, pet care, child care and transportation to and from appointments.

WHAT TO BRING TO THE HOSPITAL

The spine surgery pre-op packet containing this booklet, your pathway to healing, and any information you received preoperatively regarding your surgery and hospitalization.

Loose and comfortable clothes. For example, a shirt with buttons for patients undergoing neck surgery, a nightshirt or draw-string/elasticized pants or pajama bottoms for patients undergoing lumbar support.

Lumbar brace. If your surgeon requires you to wear a lumbar brace after surgery, arrangements for obtaining the brace will be made prior to surgery. The brace will be given to you the day of surgery.

It is recommended wearing a cotton T-shirt under your brace.

Proper shoes to walk in the halls after surgery and for discharge home. Preferably, these are shoes with a non-skid sole. Avoid "flip-flops" or slippers that do not enclose the heel of the foot.

A current list of your medications, including dosages and times you take them.

Your advanced directive (living will, power of attorney) if you have one.
Your insurance information. The hospital will bill your insurance company directly.
Personal care items, such as toothbrush, toothpaste, denture cleaner, comb or brush, skin care products, deodorant, make-up and shaving kit.
Glasses, contacts, dentures or hearing aides, as well as storage containers these items.
Something to pass the time (reading materials, knitting, crossword puzzles).
Personal CPAP equipment if you use a CPAP machine while sleeping.
DO NOT bring valuables!

THE MORNING OF SURGERY

You will be given detailed preoperative instructions regarding your medications and surgery during your Pre-Admissions Testing Area visit and/or by your surgeon. If you have any questions regarding these instructions, please ask your surgeon. Important Reminders:

Leave jewelry and all valuables at home except for ID and insurance or payment information.

Do not wear cologne or perfume ARRIVAL AT THE HOSPITAL

Your pre-admissions nurse will provide you with your arrival time the day prior to your surgery. On the night before your surgery, do not eat or drink anything after midnight. This is very important for your safety. If you do eat or drink after midnight, your surgery will be delayed or canceled.

Go to registration at the hospital and you will be escorted to the Pre-op area.

The registration representative will ask you to fill out forms about how you will pay for surgery. If you have insurance, please have your card ready.

You will be given an ID bracelet that includes your name, date of birth and doctor's name.

After you've finished registration, you'll be taken to the surgical waiting area or proceed directly to the Pre-op area. Here, a nurse will make sure you're prepared for surgery and answer any questions you may have.

GETTING READY FOR SURGERY

In the pre-op area, you'll be asked to remove any of the following items:

- Dentures and bridges
- Hearing aids
- Contact lenses/glasses
- Body piercing/jewelry
- Wigs, hairpins, combs and barrettes

The nurse might ask you to shower with an antibacterial soap, or he/her may wash the area where the surgery will be performed. You will have been given instructions to bath with an antimicrobial soap (Hibicleans) the night before surgery as well.

You'll also be asked to remove your clothes and change into a hospital gown, cap and foot covers.

The nurse will place a needle into a vein in your arm or wrist. This needle is attached to a tube that will supply your body with fluids, medication or blood during and after the surgery. This is called an intravenous (IV) line.

You will remain in the pre-op area until the surgical team is ready for you.

Patient safety is the number one priority. The nurse will ask you:

What kind of surgery are you having?

Do you have any allergies?

When was the last time you had anything to eat or drink?

Which side of your body are your symptoms on?

When you are completely ready for your surgery, an anesthesiologist will see you for your preoperative consult to review your surgical and medical history, your upcoming surgery and to answer any questions. After the anesthesiologist has seen you and all other paperwork and examinations are completed, either anesthesia personnel or the pre-op nurse may give you medication to help you relax.

Your family will be escorted to the waiting area at this time. Your operation could last for several hours, including going back to the room, intubation, the surgical procedure, and awaking from anesthesia.

Your family will be keep updated on the progress of your case.

Please have a family member hold all valuables, including money and jewelry.

GOING TO THE OPERATING ROOM

When the surgical team is ready, the operating room nurse will take you via a stretcher to the operating room. Anesthesia personal will then attach monitors to your chest, arms and other parts of your body before you're asleep. When you're asleep, a catheter may be placed in your bladder to drain urine and elastic wraps will be placed on your legs to prevent blood clots. The length of time in the operating room will depend on your condition and the procedure. Your surgeon is the best person to give you an estimated length of surgery.

RECOVERY ROOM

After the operation, the surgeon will talk with your family, briefing them on the surgery and giving any instructions. At that time, family and friends may remain in the family waiting area. They will be notified when you are in your room and ready for visitors.

WAKING UP

Typically, anesthesia medications are discontinued when the surgical procedure is complete, allowing you to wake up moments after surgery. You'll be taken to the Recovery Room, where specially trained staff and equipment monitor patients closely after surgery. While in the recovery room, you might continue to feel quite groggy. In fact, you might not even recall your time in the Post Anesthesia Care Unit (PACU). If you are having outpatient surgery, you will remain in the recovery room for one to two hours, then transferred to phase 2 for discharge. When are ready to go home, you will be given discharge instructions and prescriptions. You **MUST** have someone to drive you home. If for any reason your doctor feels you should remain overnight, Piedmont Henry Hospital offers observation care. That way you receive the benefit

of professional nursing care, yet retain your same-day surgery status if you are discharged within 23 hours. If you stay in the hospital past midnight, your insurance company may require your stay be classified as an inpatient visit and subject to a deductible. We strongly recommend that you contact your insurance company about the specifics of your policy. The most common side effects after anesthesia include nausea, sore throat and dizziness or headache. The recovery room nurses will make you as comfortable as possible and minimize any side effects as you awaken.

WHAT TO EXPECT AFTER SURGERY

Once you're more fully awake and your vital signs are stable, you'll be moved by stretcher to your hospital room.

Once in your hospital room, the nurse will perform an initial assessment and help you get settled in your room.

You can expect:

- Frequent assessments of your blood pressure, heart rate, respiratory rate and temperature.
- Frequent questions about pain, muscle spasms and nausea.
- Frequent questions relating to your spinal surgery and whether you are experiencing any numbness, tingling or weakness.
- Frequent assessment of your surgical dressing.

These are very important questions, and although it may seem like we just want to wake you up and bother you, we take these items very seriously. Your surgeon is depending on us to ask these questions. When you return to your room after surgery, you might also have one or more devices attached to you.

ACTIVITY

Depending on your type of surgery, orders will be placed as to what activity is appropriate for you.

Examples include:

- Bed rest only
- May get up to the bathroom only
- May walk as tolerated
- Physical therapy to ambulate
- Dangle legs night of surgery

It is very important for you to understand what you are allowed to do— then do it.

A physical therapist (PT) may visit you on the day after surgery. It is important for you to move either in bed or be up and walking with the nurse and/or floor staff prior to your first PT visit. Remember to use proper body mechanics when ambulating—the staff can demonstrate these for you. Not only will your PT visit be more productive if you have already been up and walking, but your recovery will be better, and you also will be preventing complications such as blood clots in your legs.

It is not uncommon to experience dizziness, lightheadedness or nausea the first time you sit on the side of the bed or stand up. It is also normal to have increased pain the first few times you try moving. The dizziness, nausea and pain will subside the more you get up and are moving.

PAIN CONTROL

After surgery, you'll experience varying levels of pain. You can expect the nursing staff to assess your pain level frequently. A rating scale of 0-10 may be used. The rating merely helps us to assess your pain and monitor your progress with pain medications. When you request pain medicine, it will be given to you either by mouth or through an IV.

Remember that it is important to control your pain level; don't let our pain become severe before you ask for your pain medication.

Remember that these medications are also PRN (as needed), so let the nursing staff know when you're in pain and need medication.

MEDICATIONS

After surgery, you will resume the medications you routinely take at home. Your surgeon may make exceptions and will discuss these with you. The medication you take while in the hospital will come from the hospital pharmacy and be given by your nurse. Please do not bring your own supply of medications to the hospital unless directed by the physician. Medications brought from home will be collected by the nurse and confirmation of the drug and dose will be conducted by the pharmacist. You **MUST** bring the bottle with the name of the drug, dosage, and frequency on the bottle.

Nausea It is not uncommon to have some nausea and/or vomiting after surgery. If this happens, please notify the nursing staff. Medications are available on a PRN (as needed) basis, so you must ask for them.

MUSCLE SPASMS

For your surgeon to gain access to specific areas of your spine during surgery, certain muscles attached to or surrounding your spine may be cut or manipulated. As a result, you may experience muscle spasms or muscle cramping during your post-operative period. Muscle spasms can be quite painful.

Depending on the type of spine surgery performed, your surgeon may order medications for muscle spasms that are available to you during your stay in the hospital, on either a scheduled or as needed basis.

CONSTIPATION

For a variety of reasons, patients become constipated (have trouble having a bowel movement) after surgery. If this is a problem, please tell your nurse. Medications and other options are available to relieve constipation.

DRAINS

Depending on the type of surgery, you may have a drain in your surgical incision. The drain will be placed during the surgery. The drain promotes healing by draining fluid from the wound or incision and preventing swelling and pooling of blood. The drain is sometimes removed on the

day after surgery but could remain in longer depending on the amount of drainage. The drainage is monitored by the nursing staff.

NUTRITION AND DIET

Depending on your type of surgery and your condition after surgery, you may be offered a clear liquid diet when you return to your hospital room. If you do not experience nausea or vomiting, your diet may be advanced to a regular diet as tolerated. All patients are ordered a diabetic diet to assist with normal glycemic control post operatively.

A protein shake may be ordered to supplement your diet.

Eating a healthy, well-balanced diet after surgery can help with wound healing.

PREVENTION OF COMPLICATIONS

As your physician discussed with you, there is a potential for complications after your surgery. We will do what we can to prevent any such complications.

PNEUMONIA

Deep-Breathing Exercises Deep-breathing exercises are performed to prevent pneumonia. Your nurse will show you how to use a device called an incentive spirometer. The spirometer helps open your airways after surgery, bringing in as much oxygen as possible. This exercise involves breathing in slowly and deeply, holding it for approximately 10 seconds and then exhaling. Perform this exercise 3-4 times a daily.

DEEP VEIN THROMBOSIS

The following devices help to prevent blood clots in your legs. Such clots are known as deep vein thrombosis. Sequential Compression Device (SCD) SCDs are devices that wrap around your legs from your ankle to your thigh. They periodically fill up with air to gently squeeze your legs and help with the circulation in your legs. You'll wear SCDs from the time you have surgery until you are walking the length of the hallways two or three times a day.

WHAT TO EXPECT ON POST-OPERATIVE DAY ONE

The day after surgery through discharge may be filled with instructions, exercises and rest. Your nurse will see that you continue to do your breathing exercises and assist you in managing your pain. If your doctor has ordered a brace, you will have been measured and/or made the necessary arrangements for the brace prior to surgery. Depending on the type of surgery, you will also be discharged on this day. **Physical Therapy** On post-operative day one, if ordered by your surgeon, a physical therapist (PT) will visit you to assess your mobility and strength. The PT and the nurse will work together to make sure you have received pain medicine before you physical therapy visit. During your session, the PT will instruct you on proper body mechanics and ways to protect your spine. The PT can also assess whether you need a walker for support. The walker may only be required temporarily during your hospitalization. The number of visits from the PT may vary from patient to patient. The PT will determine if you need more than one or two visits. If the PT feels that you would benefit from more physical therapy after you go

home, the PT will work with your physician and patient care coordinator to obtain the appropriate orders. In the hospital, you'll be walking at least two to three times per day with the nursing staff, other floor staff or a PT. The PT can also instruct you on stair climbing (if you have stairs at home) and how to put on and take off the brace (if a brace is required after your surgery).

AT DISCHARGE

A few things to think about when going home:

- Consider the type of vehicle you are going home in.

- Make sure you get in and out of the vehicle easily without extreme bending or twisting of the spine.

- You may want to consider keeping an additional pillow available to provide extra support during your ride home.

- Remember to take home all your belongings in the hospital room including clothing, cell phones, chargers and any personal items.

ACTIVITIES AND EXERCISE

Remember to use correct body mechanics and spine precautions learned in the hospital during your recovery period.

You will be given a discharge instruction packet specific for your surgery.

MEDICATIONS

Unless specifically discontinued by your surgeon, you will resume any home medications that you were taking prior to your surgery.

You may go home with a prescription for pain medications, or any other medications started in the hospital.

Take the medicine as prescribed by your surgeon.

DRIVING

You will need someone to drive you home from the hospital.

You will not be allowed to drive until your surgeon clears you to drive.

WORKING

Your surgeon will tell you when you may return to work or school.

Many factors such as your type of surgery, post-operative condition, and your occupation will influence this decision.

FOLLOW-UP APPOINTMENT

Your discharge instructions will include information concerning post-operative appointments with your surgeon, and when and how to schedule those visits.

Your surgeon may order X-rays to be completed prior to your next visit.