Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

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1. PROCEDURE SUMMARY

Procedure Performed: [Name of Surgery]

Date of Surgery: [Surgery Date]

Surgeon: [Surgeon Name]

2. WOUND CARE AND HYGIENE

- **Dressing:** [Keep dressing dry for X hours/days. Instructions for removal].
- **Incision:** [Keep the area clean. Do not apply creams or ointments unless instructed].
- **Showering:** [Specific instructions on when and how to shower].
- **Drains:** [Instructions for drain care and output logging, if applicable].

3. ACTIVITY RESTRICTIONS

- **Lifting:** Do not lift anything heavier than [X] lbs for [X] weeks.
- **Exercise:** [Walking is encouraged. Avoid strenuous activity/core exercises].
- **Driving:** Do not drive while taking narcotic pain medication.

4. MEDICATIONS

- **Pain Management:** [Medication Name, Dosage, Frequency].
- **Antibiotics:** [Medication Name, Duration].
- **Resuming Home Meds:** [Instructions on blood thinners or other regular medications].

5. DIET

[Standard/Liquid/Soft food instructions and hydration requirements].

6. FOLLOW-UP APPOINTMENTS

- **Surgical Follow-up:** [Date/Time or "Call to schedule within X days"].
- **Oncology/Pathology:** [Date/Time for review of biopsy results].

7. WHEN TO CALL THE DOCTOR

Contact the surgical office or seek immediate medical attention if you experience:

- Fever over 101F (38.3C).
- Increased redness, swelling, or foul-smelling drainage from the incision.
- Pain that is not relieved by prescribed medication.
- Shortness of breath or chest pain.
- Persistent nausea or vomiting.

8. CONTACT INFORMATION

Surgical Clinic: [Phone Number]

After-Hours Service: [Phone Number]

Signed,

[Doctor/Provider Name]
[Department of Surgical Oncology]