

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Procedure: [Insert Name of Surgery]

Surgeon: [Insert Surgeon Name]

Post-Surgical Medication Administration Instructions

Dear [Patient Name/Caregiver Name],

Below is the prescribed medication schedule to assist with your recovery. Please follow these instructions carefully to manage pain and prevent infection.

Medication Name	Dosage	Frequency/Time	Purpose	Special Notes
[e.g., Ibuprofen]	[e.g., 600mg]	Every 6 hours	Pain/Inflammation	Take with food
[e.g., Cephalexin]	[e.g., 500mg]	Twice daily	Antibiotic	Finish entire course
[Insert Med]	[Insert Dose]	[Insert Schedule]	[Insert Reason]	[Insert Note]

Pain Management Strategy:

Do not wait for pain to become severe before taking prescribed pain relief. If you experience nausea, try taking medication with a small meal unless otherwise directed.

Medication Log:

- Last Dose Taken: _____ at _____ (Time)
- Next Dose Due: _____ at _____ (Time)

When to Call the Doctor:

Contact the surgical office at [Insert Phone Number] immediately if you experience:

- Allergic reactions (rash, hives, swelling).
- Severe dizziness or fainting.
- Uncontrolled pain not relieved by medication.
- Persistent vomiting.

Sincerely,

[Authorized Signature]

[Printed Name/Title]

[Facility Name]