



Hemorrhoid Banding Discharge Instructions

Procedure: Hemorrhoid Banding

Activity: No excessive exercise today, return to normal activity as comfort allows.

Diet: Liquids and light foods then advance diet as tolerated. There are no dietary restrictions. If nauseated, return to clear liquids only (water, apple juice, tea, lemon-lime soda, etc.).

Medications: Resume usual medications or as instructed by physician.

Rx _____

General information relating to pain medications:

1. Take with food or milk to reduce stomach irritation.
2. Do not drink alcohol or make important decisions while on narcotics.
3. The medication can cause drowsiness; do not drive or do anything that requires mental alertness (using power tools).
4. Most pain medications tend to have a constipating effect; drink extra fluids and increase fiber/bulk in your diet (whole grains and cereal, fresh fruit, and vegetables).

Special Instructions: Expect some bleeding with the next bowel movement and in 7-10 days when the band cuts through. Try **NOT** to have a bowel movement for 24 hours. If no bowel movement in 72 hours, try a mild laxative, eat bran or whatever works for you.

Doctor Appointment: Call Dr. _____ for a follow-up appointment for _____
Office Phone Number: **509-338-0632**

Call Doctor If:

1. Your pain is not controlled by your pain medications.
2. You have redness, swelling, or excessive bleeding or drainage from your incision.
3. You have chills or temperature over 100.5 or other signs of infection.
4. Nausea or vomiting that is not relieved
5. You have dizziness and notice an increase in girth size of your abdomen.

OR contact PRH Same Day Services at (509) 336-7570 and ask to speak to a nurse to explain the problem you are experiencing. The nurse will advise you and help you contact your surgeon or one of their partners.

These instructions have been explained to me and I have received a copy.

Patient/Escort Signature: _____

Nurse Signature: _____ Date: _____



DISCHARGE FOLLOW-UP

Procedure: _____

Phone: _____

Okay to leave message/talk to family member? Yes/No Parent/Family Name: _____

1st Attempt Date: _____ Time: _____ By: _____ 2nd Attempt Date: _____ Time: _____ By: _____

- Left Message
- No Answer
- Spoke with patient/family

Spoke with: Patient Spouse Parent Other: _____

Is your pain controlled by your pain medications?

- Yes No: _____

Are you able to tolerate food/fluids?

- Yes No: _____

Any problems with circulation or sensation? (i.e. numbness, tingling, swelling?)

- Yes No: _____

Is your dressing clean, dry, and intact?

- Yes No: _____

Do you have any questions regarding your discharge instructions?

- Yes No: _____

Are there any concerns or compliments that you would like us to know about?

- Yes No: _____

Physician's Office Notified of concerns NA

Comments: _____

