PATIENT AFTER-CARE INSTRUCTIONS

PATIENT NAME: _____ **DOB**: _____

❒ **Common Side Effects** – Patient informed of common side effects

❒ **Sample / Prescription** – Given for: _____

❒ **Medication / Sample** – Patient encouraged to read package insert, for any rare side effects. Should any side effects occur, medication should be discontinued immediately, and call the office. If symptoms are severe you must go to the EMERGENCY ROOM!

❒ **Sample Refills** – Must call the office 7 - 14 days if able to tolerate sample medication. A script will be called into your pharmacy at that time.

❒ **Headache / Sleep / Seizure log** – Patient instructed to maintain log on a daily basis, *and should bring completed log on the next scheduled appointment.*

ALL REFILLS SHOULD BE CALLED INTO PHARMACY 5 - 7 DAYS PRIOR TO COMPLETING MEDICATION. CALLING IN ADVANCE WILL ALLOW SOME TIME FOR YOUR PHARMACY TO MAKE CONTACT WITH THE DOCTOR IF NEEDED OR CONTACT WITH YOUR INSURANCE IF AUTHORIZATION IS NEEDED.

LITERATURE & INFORMATION GIVEN

PATIENT GIVEN LITERATURE ON THE FOLLOWING:

❒ Seizure / Epilepsy ❒ PLMDS ❒ Parkinson's Disease ❒ Alzheimer's Disease ❒ Sleep Apnea
❒ Narcolepsy ❒ Stroke ❒ Baclofen Pump Implant ❒ Neuropathy ❒ VNS

RESTRICTION

❒ SHOULD NOT! Lift, Tug, Pull, Push heavy objects.
❒ SHOULD NOT! Lift more than _____ lbs over shoulders.
❒ SHOULD NOT! DRIVE until medically cleared.
❒ SHOULD NOT! Operate heavy or dangerous machinery or work in high areas such as ladders etc.
❒ Other: _____

WARNED AGAINST

❒ SHOULD NOT! Drive in heavy traffic, or busy freeways.
❒ SHOULD NOT! Gain weight. Patients should maintain weight.
❒ SHOULD wear comfortable shoes with support.
❒ SHOULD USE C-PAP / Bi-PAP on a regular basis.
❒ Patients should follow APNEA precautions.
❒ Patients should continue recommendations of all other treating physicians.
❒ Current list of medication reviewed. Patient instructed to bring an updated list on the next visit.
❒ Patients should continue taking all current medications, as prescribed.
❒ OTHER: _____
❒ Pathophysiology of his / her symptoms have been discussed with patients.

Plan for follow-up discussed with patient. Patient understands and agrees to all recommendations.

Doctor's Signature: _____ Date: _____

I HAVE BEEN ADVISED AND INSTRUCTED OF ALL RECOMMENDATIONS PRESCRIBED BY DR. KHAN. I UNDERSTAND AND AGREE TO FOLLOW ALL RECOMMENDATIONS, TO TREAT MY PROBLEMS / SYMPTOMS.

Patient Signature: _____ Date: _____