ADVANCED
EYE SURGERY CENTER

627 W. East Avenue
Chico, Ca 95926
530-342-1800

DR. PABLO ARREGUI/DR BENJAMIN GILBERT/DR HEIDI HOULIHAN/DR SEAN LISTON

CONJUNCTIVAL DISCHARGE INSTRUCTIONS

1. Because your reflexes are diminished after receiving anesthetic medications, for the next **24 hours**:
   a. You should not operate a vehicle or engage in the operation of any machinery/appliances.
   b. You should **NOT** drink any alcoholic beverages.
   c. You should **AVOID** making critical decisions.
   d. You MUST have a responsible adult (over 18 YO) stay with you after discharged from the center.
2. There are **NO** diet restrictions, although a heavy meal (burgers/fries) is not recommended. You may resume your medications unless otherwise directed by your physician.
3. If you have any discomfort, you can use any over the counter pain medications of your choice*. If your pain is severe, please call your physician's office.*
4. **DO NOT** rub wound/eye or do any heavy lifting for 1 week. You may resume normal activity in 48 hours unless instructed otherwise by your physician.
5. Your dressing (gauze eye pads) over your eye can be removed in the morning, please replace the clear shield. If you have a bandage contact lens, leave that in place until your physician removes it.
6. **If prescribed, apply ointment/drops to operative eye as directed by your physician*. Any questions about your post operative medications please contact your surgeon's office.***
7. **POST-OPERATIVE EXAMINATION:** Please return **TO YOUR PHYSICIANS OFFICE** *(not where you had surgery)* @_____on_____ for your follow -up appointment.
8. Additional instructions:
   _____
   _____

Precautions: If you have problems relating to your surgery or develop any of the following- *fever over 101, chills, difficulty breathing, excessive drainage from surgical eye, excessive pain not alleviated by OTC medications*: please call you Physician's office (895-1727). IF YOU ARE UNABLE TO REACH YOUR PHYSICIAN, YOU SHOULD GO TO THE NEAREST EMERGENCY ROOM, OR DIAL 911.

I HAVE RECEIVED A COPY OF THIS INSTRUCTIONS:

_____   _____

Patient/Guardian   Nurse Signature/DATE