Patient Label

DR. SEAN LISTON / POST-OPERATIVE INSTRUCTIONS

PENETRATING KERATOPLASTY (PKP)

1. Because your reflexes are diminished after receiving anesthetic medications, for the next 24 hours:
   a. You should not operate a vehicle, machinery, or appliances
   b. You should not drink alcoholic beverages
   c. You should avoid making any critical decisions
   d. You must have a responsible adult drive you home and stay with you after discharged from the Center**.**

2. There are no diet restrictions, although a heavy meal is not recommended. You may resume your medications unless otherwise directed by your physician.

3. You may use your eye normally following surgery (this includes reading, watching TV, computer, etc.). Restrictions are as follows:
   a. **DO NOT** rub operative eye/eyelid or do any heavy lifting for *at least* 2 weeks
   b. Leave the patch/shield covering your eye in place until your follow-up appointment; your physician will remove it for you.
   c. You may shower and wash hair 48 hours (2 days) *after* surgery
   d. No swimming for 2 weeks

4. You may have a headache and can take Tylenol or your normal over the counter pain medication for any discomfort. If prescription pain medicine was prescribed, you may take that as directed instead.

5. Additional Instructions:
   _____
   _____
   _____

6. **POST-OPERATIVE EXAMINATION:** Please return to your physician's office @ _____
   the following day in Chico / Paradise, and please take your eye bag with contents and glasses to the office. You will receive further instructions at this appointment regarding your eye drop schedule.

   <u>PRECAUTIONS:</u> If you have problems relating to your surgery or develop any of the following – fever over 101, chills, excessive drainage from the eye, excessive headache or eye pain not relieved by Tylenol, please call your physician's office @ **895-1727**. *IF YOU ARE UNABLE TO REACH YOUR PHYSICIAN, YOU SHOULD GO TO THE EMERGENCY ROOM NEAREST YOUR HOME or DIAL 911.*

   I have received a copy of these instructions

   _____   _____
   Patient/Parent/Guardian   Nurse Signature

   _____
   Date

(REV. 5/14)