

AN INPATIENT GUIDE TO ORTHOPAEDIC TRAUMA

THE ORTHOPAEDIC & REHABILITATION MEDICINE PROGRAM AT

THE BONE AND JOINT HOSPITAL OF QUEENS

A higher level of Orthopaedic and Rehabilitative care.



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member **NewYork-Presbyterian Healthcare** System

affiliate: Weill Cornell Medical College



Dear Patient,

You have been admitted to the Orthopaedic Trauma Service because your musculoskeletal system has been injured. Your musculoskeletal system is the medical term that is used to refer to your bones, joints, muscles, ligaments and tendons. Orthopaedic trauma surgeons are the medical specialists that are frequently consulted to care for injured people with fractures – also known as broken bones – and are a part of the larger team that starts you on your way to recovery.

Our Emergency Department has been designated by the New York State Department of Health as a regional Level 1 Trauma Center and treats more than 1,000 adult and pediatric trauma cases each year. This designation means that a complete support staff of physicians is always available to treat life-threatening traumatic injuries and includes specialists in surgery, neurosurgery, anesthesia, orthopaedics, interventional radiology and others.

This booklet will introduce you to our team and will give you an idea of what to expect while recuperating here at New York Hospital Queens (NYHQ) as well as after you leave. We realize that you and your family will have many questions and concerns regarding your injury, treatments, recovery and hospitalization at NYHQ. We also understand that unanticipated injuries can be a great source of anxiety and that this unplanned chain of events can be very stressful. The more informed and educated you can become about what we are doing to take care of you, the more comfortable you will be during this difficult time.

We hope that this booklet will provide a solid foundation regarding NYHQ, your injury, your treatment and recuperation. This booklet uses common words and terms to describe useful information and is meant to add to the information you receive from the medical care providers who were assigned to you while a patient at NYHQ. Please do not hesitate to ask any questions about any information in this booklet as it is important for you to be an active participant as we work together to help you recover from your injuries.

Sincerely,

Elan M. Goldwyn, M.D. Attending Orthopaedic Surgeon Orthopaedic Trauma Working side by side with your Orthopaedic Trauma Team, the inpatient physical therapists are another important part of your recovery process. Early mobility and exercises have been shown to speed up the rehabilitation process and return to prior level of function. Patients routinely receive physical therapy the day after surgery. Our physical therapists will work with you to achieve your goals and maximize your functional independence. Therapeutic exercises, transfer training and ambulation training are examples of some of the interventions performed daily that are important for your recovery. The physical therapists will follow specific and detailed orders from your doctor and will

We know that sometimes beginning physical therapy after an injury, fall, or surgery can be sore and even painful. We will help you work through this discomfort and want you to tell us if something doesn't feel right. We will all care for you with the same goal in mind. Your inpatient physical therapist, physical therapy assistant and physical therapy attendant are all here to help you return to your prior level of function as quickly and safely as possible, and look forward to working with you toward your recovery.

coordinate your sessions with the interdisciplinary team.

Sincerely,

Nicole Manfield, DPT Inpatient Physical Therapy Supervisor

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OUR TEAM

ATTENDING ORTHOPAEDIC SURGEON

A medical doctor assigned to your care who will develop your musculoskeletal treatment plan and perform any surgeries or procedures. Your Attending Orthopaedic Surgeon will meet with the team daily and/or as needed to discuss treatment options, plans of care and recommendations.

RESIDENT PHYSICIAN

A resident has a medical degree as a fully qualified physician certified to practice medicine under the supervision of an attending physician. The residents are critical members of the team, completing a five-year residency program to specialize in orthopaedic surgery.

PHYSICIAN ASSISTANT (PA)

A healthcare provider who is licensed to practice medicine under the supervision of a licensed physician; they can conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive healthcare, assist in surgery and write prescriptions.

ANESTHESIOLOGIST

A medical doctor who specializes in the use of medicines to produce a temporary, partial or complete loss of sensation and/or consciousness for patients. Your anesthesiologist will administer the medications needed to manage and control pain during, and immediately after, surgery.

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

A registered nurse is certified in providing anesthesia under the immediate and direct supervision of an anesthesiologist.

NURSE

A licensed healthcare professional who will work with other members of your healthcare team to aid you during your treatment and recovery.

PHYSICAL THERAPIST

A licensed healthcare professional who works to restore function, improve mobility and decrease pain with the goal of re-establishing a patient's prior functional level.

PHYSICAL THERAPY ASSISTANT

A licensed professional who assists in providing therapeutic treatment according to a plan developed by, and under the supervision of, a physical therapist.

PHYSICAL THERAPY ATTENDANT

A trained professional who works with other members of the team to prepare the treatment area and assist in transporting you to and from treatment.

OCCUPATIONAL THERAPIST

A trained professional who helps you to focus on maximizing your ability to regain functional independence in activities of daily living and functional mobility in the home, workplace and community, while maintaining physical, physiological and emotional health.

RADIOLOGIST

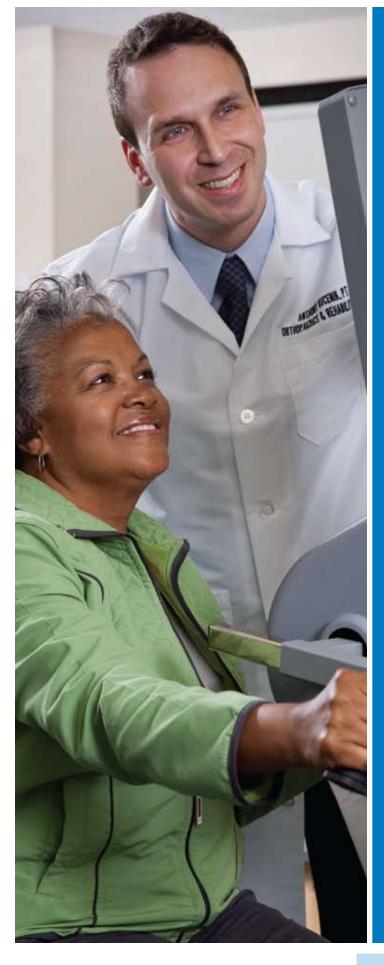
A medical doctor who specializes in diagnosing injuries by using the interpretation of medical images (x-rays, CT scans, MRIs) as well as treats diseases by means of radiation (radiation oncology) or minimally invasive, image-guided surgery (interventional radiology). Physicians rely on radiologists to correlate medical image findings with other examinations and tests.

PHYSIATRIST

A medical doctor who specializes in physical medicine and rehabilitation (PM&R) designed to decrease pain, restore function, overcome physical limitation, and enhance performance without surgery.

CASE MANAGER/SOCIAL WORKER

A registered nurse case manager/social worker monitors your hospital stay from admission to discharge. Your case manager will work closely with your attending physician to expedite tests or treatment to prevent unnecessary or prolonged hospitalization. Your social worker will assist with placement in a nursing home or rehabilitation facility, if necessary, and/or arrange accommodations to suit your needs at home and provide counseling services for medical center patients and their families.



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PHASES OF CARE

This guide has been developed to help you understand the different phases of care you may receive as a patient at New York Hospital Queens.

EMERGENCY DEPARTMENT (ED)

Almost all patients admitted to the Orthopaedic Trauma Service are first seen and evaluated in the Emergency Department (ED) and, then moved directly to the operating room, intensive care unit or a regular hospital bed depending on the seriousness of your injury.

Your care is started by an ED doctor, which may include diagnostic studies (x-rays, CT Scans, etc.), pain medications or antibiotics and contacting appropriate specialists including members of the Orthopaedic Trauma Service.

When you are first seen by a member of the Orthopaedic Trauma Service in the ED, you will provide general information about your medical history and perform a physical examination.

Once you are admitted to the Orthopaedic Trauma Service, additional orthopaedic medical history, x-rays and/or CT scans may be needed. When all information and tests are completed, your injury and treatment options will be discussed with you and could include no treatment, a sling, brace, cast or splint and/or surgery.

While you are in the ED, you may be seen by many physicians and support staff to understand the seriousness of your injury. Our physicians treat some patients who are extremely ill, and the sickest patients must be given priority. While you are there it may not be possible for your family or friends to visit you; however, your family members may contact the ED staff regarding progress about your condition.

TREATMENT USING A SLING, BRACE, CAST OR SPLINT

The purpose of applying a cast or splint is to hold the broken bone in place. This treatment allows your bone to heal straight and will help to decrease your pain. If the bone is displaced (not straight) then a reduction (straightening them out) may need to be performed first. Prior to reducing (straightening) your fracture, you will be given pain medication to minimize your pain.

SURGERY

Your condition and the nature of your injury will dictate the urgency and timing of surgery. If the Orthopaedic Trauma Service determines that you need emergency surgery, you will be taken directly from the ED to the operating room. Most orthopaedic surgeries are completed within 24 to 48 hours of the injury.

If you are admitted to the Intensive Care Unit (ICU) or to our inpatient orthopaedic unit (4W) prior to surgery, a member from the Orthopaedic Trauma Team will meet with you and your family to:

- Discuss what will happen during your surgery, how the team will repair your injury and what you can expect during your recovery.
- Explain all of the risks and benefits associated with the surgery and any alternative treatment options that may exist.
- Obtain written consent (permission) for the surgery.

Any questions or concerns that you may have should be discussed with your Orthopaedic Trauma Team at this time so that you understand what will happen during your surgery and have an idea of what to expect afterwards.

PREPARING FOR YOUR SURGERY

Unless you are having emergency surgery, you may not eat or drink anything for at least 8 hours prior to surgery to prevent you from having complications during your time under anesthesia. This will usually exclude any medications that you may take. Depending on your age and other medical conditions, you will be seen by a medical doctor either the day before or day of your surgery to have a complete physical exam to make sure you are healthy enough to have the surgery. Depending on your current condition and overall health, you may be required to take more tests and/or see a specialist such as a cardiologist or pulmonologist to make sure it is medically safe to proceed with your surgery.

When it is time for your surgery, you will be brought to the Operating Room Holding Area where a nurse will prepare you for your operation. You will also be seen by your surgeon to review the procedure and "Sign the Site" of the operation to confirm the part of the body requiring the surgery. Your anesthesiologist will also discuss your options for anesthesia. The two most common options are:

- General anesthesia: A treatment that puts you to sleep during surgical procedures so you don't feel or remember anything that happens. General anesthesia is given through intravenous drugs or inhaled gases.
- **Regional anesthesia:** An anesthetic is injected into your body and numbs the area that is being operated on.

FAMILY INFORMATION

During your surgery your family can wait in the Family Waiting Area just outside the Operating Room. After your surgery, the surgeon will return to the waiting area to speak with your family. You will be taken to the Recovery Room where you will stay for several hours while you recover from your surgery and anesthesia. Your family may visit you for a short time in the recovery room with permission from the nurse and, once you are ready to be taken back to your Hospital Room, they may visit you there. If there is a need for extra monitoring, you may be temporarily sent to another floor such as the Step Down Unit or Intensive Care Unit (ICU).

POSTPONEMENT/SURGERY DELAY

In the event that your surgery has to be postponed or delayed, you will be informed as soon as possible. Your floor nurse is your primary point of contact and can provide you with information regarding your surgical schedule.

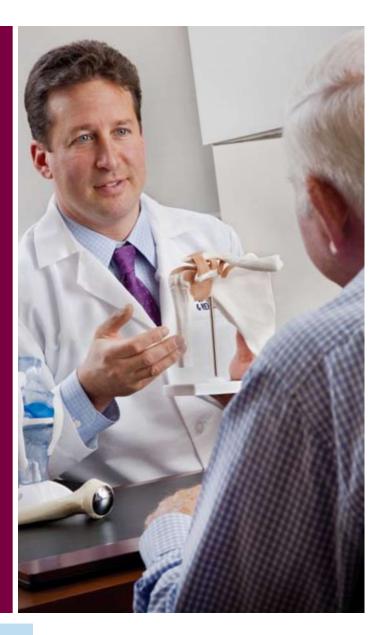


WHAT TO EXPECT EACH DAY

ROUNDS

The Orthopaedic Trauma Team, including your attending orthopaedic surgeon and several orthopaedic residents, will make rounds every morning to examine your injuries/wounds and vital signs. They will also change dressings and review any new laboratory values to update you on your care and what is planned for you for that day.

You are strongly encouraged to ask any questions or voice any concerns that you may have during this time. If your attending orthopaedic surgeon is in the Operating Room (OR) at this time you may express your questions and/or concerns to your resident, PA or floor nurse.



PHYSICAL/OCCUPATIONAL THERAPY

Once your orthopaedic surgeon or resident has placed a physical therapy order in your chart, a Physical Therapist (PT) will evaluate you in your room within 24 hours. During your initial evaluation, your PT will review the social portion of your medical history, including your level of function prior to trauma to assess how to get you back to your level of activity as safely and quickly as possible.

Your PT will work with you to develop the goals you want to achieve while you are an inpatient through discharge. Your PT will do an assessment of what you can currently manage, such as walking, strength level, balance and coordination and make recommendations based on your progression to meet your goals. Your daily physical therapy treatment rate will be based on your goals and discussed with your PT and surgeon.

Your Orthopaedic Trauma and Physical Therapy Team will make recommendations about where to continue your rehabilitation at time of discharge including home care, long-term rehabilitative care and/or subacute care. Your PT will also make recommendations to your case manager/social worker regarding durable medical equipment such as commodes, crutches, canes, etc., that would benefit your recovery.

POINT OF CONTACT

Your floor nurse is in contact with all members of your musculoskeletal care team to ensure your care plan is followed through as instructed and will be your primary point of contact while you are an inpatient at New York Hospital Queens. Please do not hesitate to ask any questions or express any concerns that you may have during your stay.

COMMON ISSUES AFTER TRAUMA

EATING AND DRINKING

If you are scheduled for surgery, you may not eat or drink anything for 8 hours prior to the surgery (NPO). This is done to prevent complications during anesthesia.

After your surgery, you can eat and drink but we recommend that you start slowly with bland foods. Unfortunately, nausea and vomiting are common problems following surgery due to the after-effects of anesthesia as well as pain medications. Your doctors will prescribe medications for you to decrease the nausea if this should occur.

PAIN MEDICATIONS

We understand that your injury has likely caused you to experience a significant amount of pain. We will do everything necessary to try to minimize the pain you are experiencing which may include prescribing mild pain pills, stronger narcotic pain pills, pain medicines injected into your skin, and/or a PCA (a pump that delivers pain medicine directly into your vein whenever you press a button.)

One of the side effects of all pain medication is constipation. Your doctors will prescribe stool softeners for you to try to minimize this side effect.

BLOOD CLOTS

After a trauma, especially to the legs, patients are at an increased risk of developing blood clots in their veins which may then break off and travel to the lungs. These clots are due to the trauma itself, as well as the prolonged time that you are spending in bed. In order to minimize the risk of developing a clot your nurse will place inflatable "squeezers" (venodynes) around your legs while you are in bed in order to increase circulation. You will also receive daily injections of a blood thinner to prevent clot formation. If you still develop a clot, despite these measures, you will be treated with long-term blood thinners to dissolve the clot.

SMOKING

It has been proven that cigarette smoke delays bone healing and increases risks associated with general anesthesia. Throughout your hospitalization and your period of recovery we strongly recommend that you try to stop smoking. We understand that this is not an easy thing to do and if you need assistance we can prescribe nicotine patches and offer smoking cessation counseling.



For further information, please visit www.nysmokefree.com for the New York State Smokers' Quitline to obtain further information to stop smoking.

COUGHING/PNEUMONIA

Prolonged bed rest, as well as anesthesia, may cause you to develop a cough and/or not breathe normally. After your surgery, your nurse will give you an "incentive spirometer." This is a small breathing tube that you will blow into throughout the day. By using this device, your lungs will function better and decrease your chance of developing pneumonia. We recommend using this device at least ten times per hour while awake.

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REHABILITATION

The recovery from your injuries will begin here as an inpatient and will continue once you are discharged from New York Hospital Queens and, in most cases, may continue over several months either at home or a different type of hospital setting as an outpatient. Please discuss your options for discharge with your case manager/social worker regarding the transition from one setting to another. Your options for outpatient rehabilitation at another facility include the following:

REHABILITATION HOSPITAL

This is typically for patients that need a considerable amount of rehabilitation care over an extended period of time. In this environment, your care will continue with a new team of therapists, nurses and physicians to help you work towards your goals of strength and function.

SKILLED NURSING FACILITY

If you need less medical supervision upon discharge from the hospital but are not independent enough to return home, a skilled nursing facility (SNF) may be an option for you. In this setting, you will also continue to work on your strengthening and rehabilitation goals.

HOME HEALTHCARE

If the Orthopaedic Trauma Team has established that you have progressed to a point where it is medically safe for you to continue your recovery in your home, you may be discharged directly from the hospital. If this is the case, your case manager/social worker will arrange for any home healthcare services you require.

OUTPATIENT THERAPY AND FOLLOW-UP APPOINTMENTS

Outpatient therapy with a physical and/or occupational therapist is often needed after discharge to help restore you to your pre-injury function. Patients will need to be able to travel to the outpatient office setting for treatment.

Your surgeon(s) will want to see you in the office for follow-up appointments after your discharge from the hospital to see how well you are recovering from your injuries. Before you leave the hospital, you will be given instructions for your follow-up care. Please also refer to our website at www.nyhq.org/Orthopaedics_and_Rehabilitation for contact and general information regarding follow up appointments.

FREQUENTLY ASKED QUESTIONS

HOW LONG DO I HAVE TO USE MY CRUTCHES/WALKER/CANE/BRACE/SPLINT?

Many fractures require protection from weight bearing until they are fully healed. Your weight bearing status will be explained to you before you are discharged from the hospital. Your crutches/walker/cane/brace/splint should be used for the period of time, as instructed, as a shorter period of time may cause complications.

CAN I SHOWER?

If your wound is closed and there is no drainage from the surgical site, your surgeon may allow you to shower. Please ask permission before doing so. If you do get the incision wet, pat dry. If you have an open wound and/or there is drainage from the surgical site, you may not shower. If you have a cast, it must be covered with plastic to keep dry; if the cast gets wet, you must return to your doctor as it must be changed.

WHEN CAN I GO BACK TO WORK/SCHOOL?

This should be discussed at your first outpatient visit with your surgeon as it depends on how your injury is healing as well as your duties, responsibilities and/or physical activity at work/school.

WHEN CAN I DRIVE?

Prior to driving, you must be off all pain medications and healed to the extent that in case of an emergency, you can perform the necessary tasks needed to avoid injuring yourself and others. This is a decision you will need to make in consultation with your doctor.

WHAT HAPPENS TO THE METAL PINS, SCREWS AND PLATES? WILL THEY STAY IN MY BODY PERMANENTLY OR WILL THEY BE REMOVED?

Most metal implants will remain safely in your body forever and are typically not a problem; the majority of patients forget they are there. If the implants do cause any pain, your surgeon will discuss the appropriate timing of removing them and the risks/benefits of doing so.

WHAT IF I HAVE A METAL ALLERGY?

The metals used in orthopaedic implants do not contain any nickel (the type of metal that causes allergies) and will not cause allergic reactions.

WILL MY IMPLANTS SET OFF A METAL DETECTOR?

Depending on the sensitivity of the security machine, some implants may set off metal detectors. Unfortunately, due to heightened security at airports if you should set off a metal detector, medical cards indicating that you have an implant are not effective. Further security measures and/or questions may be asked at which time you can show security your scar and you will be cleared for entering the terminal.

SHOULD I PUT ICE OR HEAT ON ANY OF MY SWOLLEN AREAS AND IF SO FOR HOW LONG?

You may apply ice to the injured area to decrease swelling and relieve pain every hour for 20 minutes or as instructed by your surgeon. Ice should be placed in a plastic bag and wrapped in a towel to protect your skin. Heat is not recommended to reduce swelling. If your swelling and/or pain persists, please contact your doctor.

WHEN MAY I RESUME ATHLETIC AND SEXUAL ACTIVITY?

Resuming normal activity is based on the seriousness of your injury.

HOW LONG WILL I BE IN THE HOSPITAL?

On average, trauma patients stay in the hospital between two and five days. However, your length of stay will be based on the seriousness of your injuries as well as other medical factors including progression of the healing process and any rehabilitation that may be required.

WHEN SHOULD I SEE MY DOCTOR AGAIN? DO I NEED X-RAYS FOR MY NEXT OFFICE VISIT?

Before you leave the hospital, you will be given discharge instructions with information about following up with your surgeon. Additionally, our Department also offers a weekly Post Op Trauma/Fracture Clinic on Wednesday mornings; to follow up here, please call 718-670-2558.

HOW OFTEN DO I NEED TO CHANGE MY DRESSING?

You should only change your dressing if instructed to do so by your surgeon.

WHEN DO MY SUTURES/STAPLES COME OUT? SHOULD I TAKE THEM OUT MYSELF, SEE MY LOCAL DOCTOR OR RETURN TO MY SURGEON?

In general, sutures/staples are removed by your surgeon or doctor at the rehabilitation facility approximately 2 weeks after your surgery. You should not attempt to take them out yourself.

HOW LONG WILL I NEED TO TAKE MEDICATION?

If you are on blood thinning medication or antibiotics, you will need to continue taking the medications as instructed in your discharge instructions. Pain medications should only be taken for pain as needed.

WILL I NEED TO GO TO OUTPATIENT PHYSICAL OR OCCUPATIONAL THERAPY/REHABILITATION?

Outpatient physical or occupational therapy/rehabilitation visits are often needed upon discharge from the hospital to continue working on your specific rehabilitation goals. Your therapists will continually work with your surgeons to maximize your functional recovery.

TRAUMA TERMS 101

Acetabulum: the cup-shaped hollow in the pelvis (hipbone) into which the head of the femur (thighbone) fits to form a ball-and-socket joint.

Anticoagulant: medicine that "thins the blood" and prevents blood clots.

Bones: rigid (hard) connective tissue that makes up the skeleton.

Brace: an external support that strengthens or steadies a part of the body in the correct position to aid in the healing process.

Cane: a walking stick that offers support and people lean on for balance while walking.

Cast: a shell, frequently made from plaster or fiberglass, encasing a limb to hold a broken bone (or bones) in place to avoid movement until healing is complete.

Cast Boot: a shoe which has been designed to fit over a cast. People wear cast boots to protect their casts and to help them walk as normally and comfortably as possible while wearing the cast.

Clavicle: your collarbone; links your scapula (shoulder blade) and sternum (chest bone).

Comminuted Fracture: a fracture in which the bone is splintered or crushed into several pieces.

Compartment Syndrome: a painful condition that occurs when pressure within the muscles builds to dangerous levels. This pressure can decrease blood flow, which prevents nourishment and oxygen from reaching nerve and muscle cells. This is a rare complication requiring emergency surgery to release the pressure within the compartments of the leg (fasciotomy) if it occurs.

Compound Fracture: a bone fracture associated with an open wound; this is a fracture in which the bone is sticking through the skin. This is also called an "open fracture".

Crutch: a wooden or metal staff that fits under the armpit and reaches to the ground; used by disabled persons while walking.

CT Scan: Computed tomography (CT), also known as Computed Axial Tomography (CAT), is a sophisticated x-ray procedure where multiple images are taken and a computer compiles them into complete, cross-sectional pictures ("slices") of soft tissue, bone and blood vessels.

Dislocation: a dislocation is a separation of two bones where they meet at a joint. (see joint)

Epidural Anesthesia: a local anesthetic is injected into the epidural space of the spine where it acts primarily on the spinal nerve roots causing loss of sensation and paralysis in the affected areas. Depending on the site of injection and the volume injected, the anesthetized area usually includes parts of the abdomen and pelvis as well as both legs. A catheter is often left in place which allows continuous delivery of the medication.

External Fixation: a method used to set bone fractures to allow proper alignment of the fracture. In this kind of surgery the bones are held in place by use of metal pins and rods outside of the body. When used, this type of fixation is often temporary while awaiting your definitive surgery.

Extubation: to remove the breathing tube from the airway after completion of general anesthesia.

Femur: the longest and thickest bone of the human skeleton; extends from the hip to the knee. It is commonly known as your thighbone.

Fibula: the outer and thinner of the two bones of the human leg between the knee and ankle.

General Anesthesia: a treatment that renders you unconscious during medical procedures, so you don't feel or remember anything that happens. General anesthesia is commonly produced by a combination of intravenous drugs and inhaled gasses (anesthetics).

Glenoid: this is the shallow socket of the shoulder blade where the head of the upper arm (humeral head) rests.

Hip Hemiarthroplasty: a surgical procedure used to treat hip fractures where one half of the hip joint (the "ball") is replaced with an artificial metal ball and leaves the other part (the "cup") in its natural (pre-operative) state.

Hip Precautions: are ways of moving around after hemiarthroplasty that help prevent hip dislocation or separation of the new joint until the joint heals.

Home Healthcare: is health care or supportive care provided in the patient's home by healthcare professionals, such as nurses or therapists, rather than in a hospital or skilled nursing facility, to continue to the recovery process.

Humerus: bone extending from the shoulder to the elbow.

Infection: invasion of a body part by pathogenic microorganisms (usually bacteria) which may produce subsequent tissue injury. Infection can cause problems with wound healing and/or bone healing and is a possible complication of surgery. By giving antibiotics and using sterile techniques, the chances of developing an infection are very low. If you do develop an infection it can be treated with a combination of antibiotics and/or surgery if necessary.

Intramedullary Nail (IM Nail): also known as an intramedullary rod, is a metal rod placed into the medullary cavity (the marrow) of a bone. IM nails are used to treat fractures of long bones of the body, most commonly the hip, femur, and tibia.

Intubation: the process of placing a breathing tube in your airway during general anesthesia to help you breathe.

Joint: an area where two bones come together to connect.

Ligament: a sheet or band of tough fibrous tissue connecting two bones together.

Medical Clearance: is where your overall health is evaluated by a medical doctor prior to surgery to determine whether or not it is reasonably safe for you to undergo surgery.

MRI: stands for Magnetic Resonance Imaging; a type of diagnostic imaging that uses electromagnetic imaging and allows evaluation of tissues and fluid in addition to bone.

NPO: nothing by mouth (may not eat or drink). This includes candy, gum, coffee, etc.

Oblique Fracture: bone is broken at an angle and is usually the result of a sharp angled blow to the bone.

Olecranon: the tip of the elbow; it is positioned directly under the skin of the elbow, without much protection from muscles or other soft tissues.

Open Reduction Internal Fixation (ORIF): Open reduction means the surgery is done with an incision to open the area and perform the operation. Internal fixation refers to the hardware used to hold everything together. This could be metal wires, screws, or plates. The hardware stabilizes the bones or joint until healing can take place.

Patella: a small flat triangular bone in front of the knee that protects the knee joint; it is also known as the kneecap.

Pelvis: the structure of the skeleton supporting and connecting the spine to the lower limbs.

Radius: the larger of the two bones in the forearm; it extends from the wrist to the elbow.

Reduction: a medical procedure to restore a fracture or dislocation to the correct alignment. When a bone fractures, the fragments lose their alignment in the form of displacement. For the fractured bone to heal without any deformity the bony fragments must be re-aligned to their normal position.

Scaphoid: a bone situated on the thumb-side of the wrist.

Scapula: shoulder blade; is the bone that connects the humerus (arm bone) with the clavicle (collar bone).

Skin Graft: a patch of skin that is removed by surgery from one area of the body and transplanted, or attached, to another area. Sometimes needed when a wound cannot be completely closed with stitches.

Sling: a medical device made from cloth or webbing which is designed to help a patient keep an injured body part immobile. Typically, a sling is used to support a broken or sprained arm, and consists of a loop to go around the neck and a wide swath of cloth to hold the arm in.

Soft Tissue: refers to tissues that connect, support, or surround other structures and organs of the body, not being bone.

Spinal Anesthesia: a local anesthetic is injected around the spinal cord where it acts primarily on the spinal nerve roots causing loss of sensation and paralysis in the affected areas. Depending on the site of injection and the volume injected, the anesthetized area usually includes parts of the abdomen and pelvis as well as both legs.

Spine: the series of vertebrae (bones) forming the axis of the skeleton and protecting the spinal cord.

Spiral Fracture: an angular break that occurs when excessive twisting forces are applied to a bone.

Splint: also known as "half-casts." Unlike casts, splints, often made of plaster, can be adjusted to accommodate for swelling from injuries more easily than enclosed casts. Splints also can be custom-made, especially if an exact fit is necessary. Other times, a ready-made splint will be used. These off-the-shelf splints are made in a variety of shapes and sizes, and are much easier and faster to use. They have Velcro straps, which make the splints easy to adjust, and to put on and take off.

Sprain: is an injury to a ligament; the symptoms of a sprain are typically pain, swelling, and bruising of the affected joint.

TRAUMA TERMS 101 (CONT.)

Tibia: the inner and larger of the two bones of the human leg between the knee and ankle; also known as the shinbone.

Traction: refers to the set of mechanisms for straightening broken bones.

Transverse Fracture: a fracture in which the break is across the bone, at a right angle to the long axis of the bone.

Ulna: the inner and thinner of the two bones of the human forearm.

Urinary/Foley Catheter: this is a tube inserted into the urinary bladder for drainage of urine. The urine drains through the tube and collects into a plastic bag.

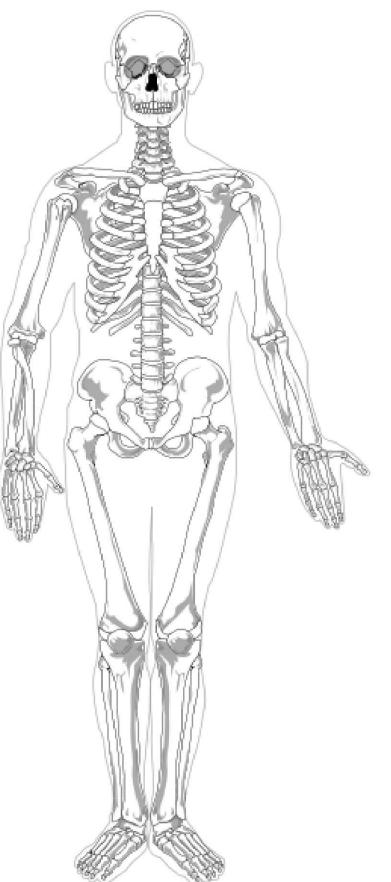
Venodynes: large plastic stockings that inflate and deflate in a cycle. These boots help to prevent blood clots from forming in the deep veins of the legs.

Walker: or walking frame is a tool for those who need additional support to maintain balance or stability while walking.

Weight bearing status: ability of the body to resist or support weight. Every patient and every injury is assigned a weight bearing status as determined by the orthopaedic attending. This status tells the patient and physical therapist what activities may or may not be performed, and for how long.

X-ray: is a quick, painless test that produces images of the structures inside your body — particularly your bones.

MY INJURIES (CIRCLE BELOW)



LIST OF MY INJURIES

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MY TEAM

ATTENDING ORTHOPAEDIC SURGEON:
RESIDENT PHYSICIAN:
PRIMARY CARE PHYSICIAN:
ADDITIONAL PHYSICIAN:
NURSE(S):
SOCIAL WORKER:
CASE MANAGER:
PHYSICAL THERAPIST:
OCCUPATIONAL THERAPIST:
ADDITIONAL:

CONTACT INFORMATION AND LOCATIONS

NEW YORK HOSPITAL QUEENS

56-45 Main Street Flushing, NY 11355

Hospital Main Number: 718-670-2000 Patient Information: 718-670-1111 Case Management: 718-670-1284

Social Work: 718-670-1300

4W Nursing Station: 718-670-3131/3132 4W Nurse Manager Voicemail: 718-670-2130

DEPARTMENT OF ORTHOPAEDICS & REHABILITATION

Inpatient Physical Therapy:

Main Line: 718-670-1290

Outpatient Physical and Occupational Therapy:

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