Date: [Date]

To: [Receiving Provider/Physical Therapist Name]
Facility: [Facility Name]
Fax/Phone: [Contact Information]

RE: Transfer of Care for Post-Operative Rehabilitation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Surgery: [Date of Surgery]
Procedure: Total Hip Arthroplasty (THA), [Left/Right] Side

Surgical Details:
Surgical Approach: [Anterior / Posterior / Lateral / Other]
Fixation: [Cemented / Press-fit / Hybrid]
Weight Bearing Status: [Weight Bearing as Tolerated / Partial Weight Bearing / Non-Weight Bearing]

Precautions:
[List specific hip precautions here, e.g., No flexion > 90 degrees, no adduction, no internal rotation]

Clinical Summary:
The patient has successfully completed the acute phase of recovery following a total hip replacement. The surgical wound is [healing well/staples removed/sutures intact]. Currently, the patient is utilizing [walker/crutches/cane] for ambulation.

Rehabilitation Goals:
1. Progressive strengthening of hip abductors and extensors.
2. Restoration of functional range of motion within precaution limits.
3. Gait training to normalize mechanics and transition to least restrictive device.
4. Independence with activities of daily living (ADLs) and home exercise program.

Medications:
[List relevant medications, e.g., Anticoagulants, Pain Management]

Please contact my office at [Phone Number] if there are any signs of wound dehiscence, excessive swelling, or unexpected neurological deficits.

Sincerely,

[Your Name/Surgeon Name]
[Your Title]
[Organization Name]