

**Date:** [Date]

**To:** [Receiving Clinician/Facility Name]

**From:** [Referring Surgeon/Clinician Name]

**Subject:** Transfer of Care - Post-Operative Rotator Cuff Repair Rehabilitation

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**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Date of Surgery:** [Surgery Date]

**Procedure:** [Type of Repair, e.g., Arthroscopic RCR, Biceps Tenodesis, Subacromial Decompression]

**Clinical Summary:**

The patient is [Number] weeks post-operative following a repair of the [Specific Tendon: Supraspinatus/Infraspinatus/Subscapularis]. Intraoperative findings included [Note Tear Size: Small/Medium/Large/Massive] and tissue quality was [Description]. Fixation was achieved using [Number] anchors.

**Current Status:**

At the time of transfer, the patient is:

- Wearing a sling/abduction pillow: [Yes/No]
- Current range of motion: [Passive/Active limits]
- Wound status: [Healed/Sutures removed]
- Neurovascular status: [Intact/Notes]

**Rehabilitation Protocol & Precautions:**

Please progress the patient according to the attached [Protocol Name/Phase]. Key restrictions include:

- No active shoulder elevation until: [Date]
- No resisted internal rotation until: [Date] (if subscapularis repair)
- Weight-bearing restrictions: [e.g., NWB for 6-12 weeks]
- Other: [Specific instructions]

**Goals for Next Phase:**

[Insert specific goals, e.g., Achieve 140 degrees PROM flexion, initiate active-assisted ROM, pain management].

**Follow-up Schedule:**

The patient is scheduled for a follow-up appointment with my office on [Date].

Please contact my office at [Phone Number] or [Email] if there are any complications, such as excessive pain, signs of infection, or unexpected loss of motion.

Sincerely,

[Signature]

[Printed Name]

[Credentials/Title]