

Date: [Insert Date]

To: [Receiving Provider Name/Facility]

From: [Surgeon Name/Department]

Subject: Post-Operative Rehabilitation Transfer of Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Surgery: [Date of Procedure]

Procedure Performed: [e.g., Posterior Lumbar Interbody Fusion (PLIF) at L4-L5]

Clinical Summary:

The patient is being referred for outpatient physical therapy following a spinal fusion. The surgical procedure was completed without complications. At the time of discharge, the patient's neurological status is [stable/improving].

Post-Operative Precautions (BLT Restrictions):

Until further notice, the patient must adhere to the following restrictions:

- **No Bending:** No forward or lateral flexion at the waist.
- **No Lifting:** No lifting, carrying, pushing, or pulling items over [e.g., 5-10] lbs.
- **No Twisting:** Avoid any trunk rotation or torsional movements.

Rehabilitation Goals:

- Normalize gait and improve independent mobility.
- Gentle core stabilization (isometrics only).
- Instruction in proper body mechanics for activities of daily living.
- Education on neutral spine positioning.

Wound Status: [e.g., Incision is clean, dry, and intact. Sutures/staples to be removed on [Date]].

Follow-up Appointment: The patient is scheduled for a post-operative review with the surgical team on [Date].

Please contact our office at [Phone Number] if there are any signs of neurological deficit, increased drainage, or worsening pain.

Sincerely,

[Surgeon Signature]

[Credentials]

[Contact Information]