

Date: [Date]

RE: [Patient Name]

DOB: [Patient Date of Birth]

Date of Surgery: [Surgery Date]

To: [Receiving Clinician/Physiotherapist Name]

Dear [Clinician Name],

This letter is to formally transfer the post-operative rehabilitative care of [Patient Name] to your facility. The patient underwent an **Anterior Cruciate Ligament (ACL) Reconstruction** on [Date].

Surgical Details:

- **Surgeon:** [Surgeon Name]
- **Graft Type:** [e.g., Bone-Patellar Tendon-Bone / Hamstring / Quad / Allograft]
- **Concomitant Procedures:** [e.g., Meniscal repair, Chondroplasty, MCL repair]
- **Fixation Method:** [Details if relevant]

Post-Operative Instructions & Restrictions:

- **Weight Bearing Status:** [e.g., Weight bearing as tolerated / Partial WB / Non-WB]
- **Bracing:** [e.g., Locked in extension / Range of motion 0-90 / No brace]
- **Range of Motion Limits:** [Specify limits if applicable]
- **Specific Contraindications:** [e.g., No isolated open-chain hamstring work for 6 weeks]

Current Clinical Status:

[Insert brief summary of current progress, including current ROM, swelling, and muscle activation status.]

Rehabilitation Goals:

- Restore full terminal knee extension.
- Normalize gait pattern.
- Progressive quadriceps and lower extremity strengthening.
- Proprioceptive and neuromuscular control training.

Please find the attached formal rehabilitation protocol and operative report for your records. If you have any questions regarding this patient's care, please do not hesitate to contact our office.

Sincerely,

[Your Name/Signature]

[Your Title]

[Your Organization]

[Contact Information]