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 Procedure]

Procedure Performed: Lumbar Laminectomy (Levels: [e.g., L4-L5])

Clinical Summary:
The patient underwent an elective lumbar laminectomy for the treatment of [e.g., spinal stenosis/radiculopathy]. The procedure was completed without complications. The patient is now cleared to begin formal outpatient physical therapy for post-operative rehabilitation and functional restoration.

Current Status:
- Incision: [e.g., Healing well/Sutures removed]
- Neurological Status: [e.g., Stable, improving weakness/numbness]
- Weight Bearing: Full weight bearing as tolerated

Rehabilitation Goals:
1. Improve core and lumbar stability.
2. Increase functional mobility and tolerance for daily activities.
3. Restore lower extremity strength and flexibility.
4. Education on proper body mechanics and ergonomics.

Precautions and Restrictions:
- No lifting, pushing, or pulling > [e.g., 10 lbs] for [Number] weeks.
- Avoid excessive bending, lifting, or twisting (BLT restrictions).
- Avoid prolonged sitting or standing; frequent position changes encouraged.

Plan of Care:
- Frequency: [e.g., 2-3 times per week] for [Number] weeks.
- Modalities: As indicated for pain management.
- Manual Therapy: Soft tissue mobilization as needed (avoid direct pressure on surgical site).

Please provide a progress report following the initial evaluation and at 4-week intervals. If the patient experiences a sudden increase in neurological deficits, uncontrolled pain, or signs of wound infection, please contact my office immediately.

Sincerely,

[Surgeon Name/Signature]
[Title/Practice Name]
[Phone Number]