Date: [Date]

RE: Transfer of Care - Achilles Tendon Repair Rehabilitation

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Surgery: [Date of Surgery]
Procedure: [Type of Repair, e.g., Open/Percutaneous Achilles Tendon Repair]

Dear [Receiving Provider/Physical Therapist Name],

This letter serves to formally transfer the postoperative rehabilitation care of the above-named patient to your facility. The patient is currently [Number] weeks post-repair and is progressing through the recovery phase.

Intraoperative Findings & Technique:
[Brief details of tear location and suture technique used]

Current Status:
- Weight Bearing Status: [e.g., Non-weight bearing / Touch-down / Full in boot]
- Range of Motion: [e.g., Neutral to 20 degrees plantarflexion]
- Orthosis: [e.g., Controlled Ankle Motion (CAM) boot with 3 heel wedges]

Rehabilitation Goals & Restrictions:
- Avoid passive dorsiflexion beyond [Degree] until [Week Number].
- Transition to [Weight Bearing Status] starting [Date].
- Wean heel wedges at a rate of [One wedge per week].
- Focus on: [e.g., Scar mobility, edema control, sub-maximal isometric strengthening].

Precautions:
- No impact activities or eccentric loading until cleared by the surgical team.
- Monitor for signs of wound dehiscence or sural nerve irritation.

Follow-up Schedule:
The patient is scheduled for a follow-up orthopedic review on [Date].

Please find the detailed surgical protocol attached. If there are any concerns regarding the patient's progress or the integrity of the repair, please contact my office immediately.

Sincerely,

[Surgeon Name]
[Clinic Name]
[Contact Information]