

Date: [Date]

To: [Receiving Therapist/Facility Name]

From: [Referring Surgeon/Provider Name]

Subject: Transfer of Care: Post-Operative Rehabilitation for Total Shoulder Arthroplasty (TSA)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Surgery: [Surgery Date]

Procedure: Total Shoulder Arthroplasty (Anatomic / Reverse)

Clinical Summary:

The patient is status-post Total Shoulder Arthroplasty. The intra-operative findings were [briefly describe, e.g., severe osteoarthritis, rotator cuff intact/deficient]. The prosthesis is stable, and there were no immediate surgical complications.

Current Status:

At the time of this transfer, the patient is [Number] weeks post-op. Current neurovascular status is intact. Pain is managed with [Medications/Modalities].

Rehabilitation Protocol & Restrictions:

Please follow the attached [Protocol Name] protocol with the following specific instructions:

- **Weight Bearing:** [Non-weight bearing / As tolerated]
- **Range of Motion Limits:** [e.g., No external rotation beyond neutral for 6 weeks]
- **Sling Use:** [e.g., Continuous for 4 weeks except for hygiene/exercises]
- **Strengthening:** [e.g., No active motion or resisted exercise until Week 6]

Goals of Care:

1. Protect the surgical repair and subscapularis (if anatomic).
2. Gradually restore passive and active range of motion.
3. Improve functional independence with ADLs within restrictions.
4. Long-term strengthening of the deltoid and scapular stabilizers.

Follow-up:

The patient is scheduled for a follow-up appointment with my office on [Date]. Please provide a progress report prior to that date.

Thank you for your assistance in this patient's recovery.

Sincerely,

[Signature]

[Printed Name]

[Contact Information]