Date: [Date]

To: [Receiving Physiotherapist/Rehabilitation Center Name]
From: [Surgical Department/Surgeon Name]
Re: Post-Operative Rehabilitation Transfer of Care

Patient Information

- **Name:** [Patient Full Name]
- **DOB:** [Date of Birth]
- **Hospital Number:** [ID Number]
- **Date of Surgery:** [Date]

Clinical Summary

Diagnosis: [Type of Pelvic Fracture, e.g., Open Book, Vertical Shear, Acetabular]

Procedure: [Type of Fixation, e.g., ORIF with Plates and Screws, External Fixation]

Surgical Findings: [Brief description of stability achieved]

Weight Bearing Status (Current)

Right Lower Limb: [NWB / PWB % / TDWB / WBAT]
Left Lower Limb: [NWB / PWB % / TDWB / WBAT]

Duration of Restrictions: [Number of weeks] weeks post-op.

Rehabilitation Plan & Precautions

- **Range of Motion:** [e.g., Maintain hip ROM within pain limits, No hip flexion > 90 degrees]
- **Strengthening:** [e.g., Isometric gluteal/quad sets, No resisted abduction]
- **Mobility Goals:** [e.g., Independent with frame, Stairs assessment]
- **Contraindications:** [e.g., No bridge exercises, No heavy lifting]

Follow-up Schedule

- **Wound Check/Suture Removal:** [Date/Location]
- **Orthopedic X-ray Review:** [Date/Location]

Contact for Clinical Concerns: [Phone Number/Email]

Sincerely,

[Signature]
[Printed Name and Title]