Date: [Insert Date]

To: [Receiving Facility/Physician Name]
From: [Sending Physician/Surgeon Name]
Subject: Transfer of Care - Post-Operative Amputation Rehabilitation

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Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Surgery: [Date of Amputation]

Procedure: [Level of Amputation: e.g., Left Above Knee / Right Below Knee Amputation]

Reason for Amputation: [e.g., Peripheral Artery Disease, Diabetes Complications, Trauma, Infection]

Current Clinical Status:
- Wound Status: [e.g., Sutures/staples intact, healing well, drainage description]
- Pain Management: [Current medications and efficacy]
- Comorbidities: [List relevant conditions]

Weight Bearing Status: [e.g., Non-weight bearing on affected limb, Weight bearing as tolerated on contralateral limb]

Rehabilitation Goals:
1. Limb shaping and edema management (shrinkers/compression).
2. Contracture prevention (stretching and positioning).
3. Strengthening of core and remaining extremities.
4. Functional mobility training and fall prevention.
5. Evaluation for future prosthetic candidacy.

Follow-Up Appointments:
- Surgeon Follow-up: [Date/Time]
- Suture/Staple Removal: [Date]

Attachments:
- Operative Report
- Current Medication List
- Recent Lab Results

Please contact my office at [Phone Number] for any questions regarding this patient's surgical recovery.

Sincerely,

[Physician Signature]
[Printed Name and Credentials]
[Facility Name]