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**Date:** [Insert Date]

**From:**

[Referring Physician/Surgeon Name]

[Department/Facility Name]

[Phone Number]

**To:**

[Receiving Therapist/Facility Name]

[Facility Address]

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**RE: Transfer of Care / Physical Therapy Referral**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Date of Surgery:** [Surgery Date]

**Procedure:** [Specific Surgical Procedure Performed]

**Diagnosis:** [ICD-10 Code / Clinical Diagnosis]

**Clinical Summary:**

The patient underwent the above-mentioned procedure on [Date]. The intraoperative course was [uneventful/noted for: details]. The patient is now ready to begin formal post-surgical rehabilitation to restore function, strength, and mobility.

**Precautions and Restrictions:**

- **Weight Bearing Status:** [e.g., Full, NWB, PWB 50%, Toe-touch]
- **Range of Motion Limits:** [e.g., Limit flexion to 90 degrees]
- **Bracing/Durable Medical Equipment:** [e.g., Hinged knee brace, sling, walker]
- **Other Restrictions:** [e.g., No heavy lifting, no driving]

**Rehabilitation Goals:**

- [Goal 1: e.g., Increase active ROM]
- [Goal 2: e.g., Gait training]
- [Goal 3: e.g., Pain management]

**Follow-Up Plan:**

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

**Frequency/Duration:**

[e.g., 2-3 times per week for 6 weeks]

Sincerely,

[Signature]

[Printed Name and Credentials]

[NPI Number]