

Date: [Date]

To: [Receiving Provider Name/Facility]

From: [Surgical Provider Name/Facility]

Re: Transfer of Care for Post-Operative Rehabilitation

Patient Information

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Surgery Date: [Date of Procedure]

Clinical Summary

Procedure Performed: [Specific Procedure Name, e.g., Left Total Knee Arthroplasty]

Diagnosis: [Primary Diagnosis/ICD-10 Code]

Surgical Approach/Findings: [Brief Description of Technique or Hardware Used]

Post-Operative Status

- **Incision Status:** [e.g., Sutures/Staples intact, Steri-strips applied]
- **Weight Bearing Status:** [e.g., Full, PWB 50%, Non-weight bearing]
- **Current Medications:** [List DVT prophylaxis, Analgesics, Antibiotics]
- **Complications:** [Note any intraoperative or immediate post-op issues]

Rehabilitation Plan & Goals

Range of Motion Goals: [e.g., Achieve 0-90 degrees by Week 2]

Strength/Function Goals: [e.g., Independent ambulation with rolling walker]

Specific Precautions: [e.g., No hip flexion > 90 degrees, No lifting > 5 lbs]

Follow-Up Schedule

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

Please contact [Surgeon Name/Office Number] for any clinical concerns regarding the surgical site or acute changes in status.

Sincerely,

[Signature]

[Provider Name and Title]

[Contact Information]