

Lower Extremity Orthopaedic Surgeries

Post-operative discharge summary

Physician Directed Orders for Rehabilitation (to accompany the handover tool)

Client name: _____	DOB: _____
Diagnosis: _____	GMFCS: _____
Date of surgery: _____	Surgery Performed: _____

Weight bearing status:

Post-op: NWB Touch WB Partial WB x _____ weeks post-op WBAT
Specify extremity: bilateral LE limb specific: _____
Progress to: Partial WB Pool weight bearing/tilt table (PWB)
 Touch WB @ ____ weeks post-op
Progress to WBAT at _____ weeks post-op

Immobilization:

<i>Item:</i>	<i>Duration:</i>	
Casting	x _____ weeks	<input type="checkbox"/> Bivalved at _____ weeks post-op
Knee Immobilizers	x _____ weeks	<input type="checkbox"/> Remove for Therapy
Hip abduction bar	x _____ weeks	<input type="checkbox"/> Remove for Therapy
Hip abduction wedge	x _____ weeks	<input type="checkbox"/> Remove for Therapy
Other: _____	x _____ weeks	<input type="checkbox"/> Remove for Therapy

CPM:

ROM: _____ Number of Hours: On: _____ Off: _____

Orthoses (AFO/KAFO): Holland Bloorview Other _____ Required at _____ weeks post-op

LEFT	<input type="checkbox"/> Hinged	<input type="checkbox"/> Hinged (Locked)	<input type="checkbox"/> Rigid	<input type="checkbox"/> Ground Reaction
RIGHT	<input type="checkbox"/> Hinged	<input type="checkbox"/> Hinged (Locked)	<input type="checkbox"/> Rigid	<input type="checkbox"/> Ground Reaction

Please specify any other activity restrictions for rehab:

Follow up appointment:

Holland Bloorview SickKids Other @ _____ Weeks X-rays required: Yes No

Physician's Name (Print): _____

Physician's Signature: _____ Date: _____