Holland Bloorview
Kids Rehabilitation Hospital

Holland Bloorview Kids Rehabilitation Hospital
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Lower Extremity Orthopaedic Surgeries

Post-operative discharge summary

Physician / Nurse Practitioner 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:

Item:	*Duration:*	
Casting	x_____ weeks	☐ Bivalved at _____ weeks post-op
Knee Immobilizers	x_____ weeks	☐ Remove for Therapy
Hip abduction bar	x_____ weeks	☐ Remove for Therapy
Hip abduction wedge	x_____ weeks	☐ Remove for Therapy
Other: _____	x_____ weeks	☐ Remove for Therapy

CPM:

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

Orthoses (AFO/KAFO): ☐ Holland Bloorview ☐ Other _____ Required at_____weeks post-op

LEFT	☐ Hinged	☐ Hinged (Locked)	☐ Rigid	☐ Ground Reaction
RIGHT	☐ Hinged	☐ Hinged (Locked)	☐ Rigid	☐ Ground Reaction

Please specify any other activity restrictions for rehab:

Follow up appointment:

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

Physician / Nurse Practitioner's Name (Print): _____

Physician / Nurse Practitioner 's Signature: _____ Date: _____