11444

Patient Label

unitedregional

Orthopedic Transfer Form

rev 03/07 orthtf.jsn

This form is to be completed by referring Orthopedic Physician and sent to _____ along with patient at time of transfer.

Requesting physician: _____
Date of request: _____

See transfer form for diagnosis and surgery. See post op note for details.

The patient's next follow-up visit with Orthopedist is _____.

The patient is approved for: (circle the appropriate answer(s))

Right Leg	non	partial	as tolerated	full weight
Left Leg	non	partial	as tolerated	full weight
Right Arm	non	partial	as tolerated	full weight
Left Arm	non	partial	as tolerated	full weight

The current CPM setting is: _____

The CPM shall be increased daily _____ degrees to _____ degrees.

The patient requires the following equipment: _____
_____

Stitches/staples **may** or **may not** be removed by nursing staff (circle one)

Stitches/staples should be removed on the following date _____

Hip Precautions (circle all that apply): Aframe Abduction Brace Ted Hose
Ortho chair Walker FCD or SCD

Additional notes:

_____
_____
_____

Physician Signature: _____

1/17/07