



Bluewater Health

PHYSIOTHERAPY DISCHARGE NOTE

Surgeon: _____

Diagnosis: _____

Surgery: _____

Surgery Date: _____

Precautions and Treatment Limitations:

Hip precautions: x _____ weeks

No hip flex > 90°

No crossing legs

No twisting

Other: _____

Shoulder precautions: x _____ weeks

Ultra-sling IV x _____ weeks

Limit PROM ER x _____ degrees

Activity Tolerance:

Activity as tolerated

Other: _____

Weight Bearing Status: _____

Function Measures:

1. ROM _____

2. Strength _____

3. Ambulation _____

4. Other _____

Patient is aware that bundled funding is available for their Outpatient Physiotherapy, but has opted for private-paid option (check only if applicable)

Signature: _____

Date: _____