



Grey Bruce
Health Network

TOTAL HIP REPLACEMENT COMMUNITY CARE STAGE CLIENT COMMUNICATION FORM

Therapist: _____

Signature: _____

Agency: _____

Phone #: _____ Date: _____

Questions/Comments

Six Week Follow Up			Three Month Follow Up		
	YES	NO		YES	NO
May I place full weight on my leg?	<input type="checkbox"/>	<input type="checkbox"/>	May I sit on the bottom of my bathtub?	<input type="checkbox"/>	<input type="checkbox"/>
Do the movement restrictions still apply?	<input type="checkbox"/>	<input type="checkbox"/>	Do the movement restrictions still apply?	<input type="checkbox"/>	<input type="checkbox"/>
May I start to drive again?	<input type="checkbox"/>	<input type="checkbox"/>	May I resume all of my usual activities such as: (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
May I lie on my operated side?	<input type="checkbox"/>	<input type="checkbox"/>	May I resume my recreational activities such as (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
May I lie on my side without a pillow between my legs?	<input type="checkbox"/>	<input type="checkbox"/>	Should I avoid certain activities? (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Additional Questions/Comments: 			 		
			Additional Questions/Comments: 		
Physician Comments/Orders: 			Physician Comments/Orders: 		
Date: Physician Signature			Date: Physician Signature		

Please return this form to your therapist following your doctor's appointment

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