



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?			May I sit on the bottom of my bathtub?		
Do the movement restrictions still apply?			Do the movement restrictions still apply?		
May I start to drive again?			May I resume all of my usual activities such as: (specify: _____)		
May I lie on my operated side?			May I resume my recreational activities such as (specify: _____)		
May I lie on my side without a pillow between my legs?			Should I avoid certain activities? (specify) _____		

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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