



**FRACTURED HIP
COMMUNITY CARE STAGE
CLIENT COMMUNICATION FORM**

GREY BRUCE HEALTH NETWORK

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: _____

Date: _____

Physician Signature: _____

Physician Signature: _____

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

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