Grey Bruce Health Network

TOTAL HIP REPLACEMENT
COMMUNITY CARE STAGE
CLIENT COMMUNICATION FORM

Therapist: _____ **Signature:** _____

Agency: _____ **Phone #:** _____ **Date:** _____

Questions/Comments

Six Week Follow Up	YES	NO
May I place full weight on my leg?		
Do the movement restrictions still apply?		
May I start to drive again?		
May I lie on my operated side?		
May I lie on my side without a pillow between my legs?		

Additional Questions/Comments:

Three Month Follow Up	YES	NO
May I sit on the bottom of my bathtub?		
Do the movement restrictions still apply?		
May I resume all of my usual activities such as: (specify:_____)		
May I resume my recreational activities such as (specify: _____)		
Should I avoid certain activities? (specify) _____ _____ _____ _____		

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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