GREY BRUCE HEALTH NETWORK

FRACTURED HIP
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

CP-FH-235
Approved May 2007

Review May 2009