Alberta Health Services

Affix patient label within this box.

Orthopedic Transfer Orders

Allergies		
Sending Facility	Unit	Date of Transfer *(yyyy-Mon-dd)*
Receiving Physician	Receiving Facility	
Diagnosis		
Secondary Diagnosis(es)		
Surgical Procedure		Date of surgery *(yyyy-Mon-dd)*
Complications		
Nutrition		

Check the attached documentation

☐ Lab tests ☐ Medication Profile ☐ Occupational Therapy ☐ Physical Therapy

Weight Bearing Status

Lower Extremity				**Upper Extremity**			
Description	Right (✓)	Left (✓)	Approximately how long?	Description	Right (✓)	Left (✓)	Approximately how long?
NWB				NWB			
Feather WB				Modified WB gutter			
PWB							
WBAT				Full WB			

☐ Type of splint/brace _____

Use of splint/brace ☐ On at all times, except for hygiene ☐ Off at night ☐ On for ambulation only ☐ Off for physical therapy

Follow-up

Wound Care _____

Removal of Sutures/Staples	Movement Precautions

Follow-Up with Physican *(specify name)*		In _____ ☐ days ☐ weeks
☐ In OPD at *(specify location)*	Date of Follow-Up *(yyyy-Mon-dd)*	Time *(hh:mm)*
Recommended follow-up with Family Physician *(specify name)*		In _____ ☐ days ☐ weeks
☐ Via Telehealth	Date of Follow-Up *(yyyy-Mon-dd)*	Time *(hh:mm)*
Nurse Name *(print)*	Signature	Date *(yyyy-Mon-dd)*
Physician Name *(print)*	Signature	Date *(yyyy-Mon-dd)*