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

<table>
<thead>
<tr>
<th>Weight Bearing Status</th>
<th>Lower Extremity</th>
<th>Upper Extremity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Right (✓)</td>
<td>Left (✓)</td>
</tr>
<tr>
<td>NWB</td>
<td>NWB</td>
<td></td>
</tr>
<tr>
<td>Feather WB</td>
<td>Modified WB gutter</td>
<td></td>
</tr>
<tr>
<td>PWB</td>
<td>Full WB</td>
<td></td>
</tr>
<tr>
<td>WBAT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Type of splint/brace Use of splint/brace
☐ Off at night
☐ Off for physical therapy

Follow-up

Wound Care

Removal of Sutures/Staples | Movement Precautions

Follow-Up with Physician (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)