

Information from your orthopedic surgeon for your occupational physician

Knee disorders and work

Date...../...../200.....

Patient:

Name:

Date of birth:/...../19.....

Orthopedic surgeon:

Name:

Hospital:

Place:

Telephone: -

Dear colleague,

Today I was consulted by your patient, who is currently working / on sickleave*

In order to start rehabilitation / to prevent sickleave* I would like to give you the following information:

(Provisional) diagnosis:

- ☐ Meniscal tear ☐ Ligament tear ☐ Arthrosis ☐ Patellar femorale syndrome
- ☐ Other/explanation*

Proposed trajectory:

- Additional diagnostics** Expected date / Explanation
- ☐ MRI
- ☐ Other/explanation*

Therapy

- ☐ Expectative
- ☐ Conservative ☐ Rest during weeks
- ☐ Exercise therapy Physical therapy / Exercise therapy*
- ☐ Medication, viz.
- ☐ Injection, viz.
- ☐ Invasive, arthroscopic operation
- ☐ Other/explanation*

Current functional limitations, from medical perspective:

- | | not limited | limited | not allowed |
|-----------------------------------|----------------------------------|--|--------------------------|
| Kneeling or squatting | ☐ | ☐ | ☐ |
| Walking stairs | ☐ | ☐ | ☐ |
| Sitting during workday | ☐ ± 8 hrs | ☐ | ☐ |
| Standing during workday | ☐ 6-8 hrs | ☐ | ☐ |
| Walking during workday | ☐ 6-8 hrs | ☐ | ☐ |
| Other disabilities / explanation* | | | |
| Regular change of posture | ☐ wanted | ☐ not necessary | |

Provisional prognosis:

I expect this patient to recover completely / almost completely / limited* within weeks

I expect that this patient can perform his usual activities after weeks

Next appointment with the patient: ☐ not ☐ within..... weeks

Authorization:

.....(name patient)

hereby declares to give permission for exchanging the above information to his/her occupational physician. This permission regards only consultation necessary to gain sufficient information for adequate support during sick leave or for a rehabilitation plan and is only valid during the current episode of complaints. This information can only be used by the above mentioned physicians and the researchers. This information can not be distributed to third parties without my permission. The purpose of this information exchange is clear to me.

Signature of patient:

City: Date/...../ 200.....

* strike through what is not applicable.