MIDLANDS orthopaedics & NEUROSURGERY

Physical Therapy Request

Rx

Patient - please fill your name, DOB, and evaluation date before your appointment.

FOR (NAME)_____ DOB:_____

ADDRESS_____DATE_____

1. LEFT
    i. Presence of left artificial hip joint - **Z96.642**
2. RIGHT
    i. Presence of right artificial hip joint **- Z96.641**
3. BILATERAL
    i. Presence of artificial hip joint, bilateral - **Z96.643**

Please evaluate both hips in the above patient for range of motion and provide a report on my standardized form included.

AND

Please FAX to **803-933-6339** and give the patient a copy.

A note from Dr. Gross:

"Dear Physical Therapist,

The person presenting this form has had a hip surface replacement performed by Dr. Thomas P. Gross _____ weeks/years ago. We are asking that you objectively evaluate his/her hip and send me a report. If the patient is less than one year postop, the hip cannot be pushed into extreme flexion, adduction and internal rotation. (See form). Please record the range of motion that can be achieved by gentle examination in this case. If the patient is approximately six weeks postop, please review and assist them with my Phase II Hip Exercise Program. The patient has been instructed to bring this with him/her in this situation."

Thomas P. Gross, MD

Thomas P Gross, MD

Digitally signed by Thomas P Gross, MD
Date: 2026.02.05 09:20:30 -05'00'

HIP FOLLOW-UP

— PHYSICAL EXAM

MIDLANDS orthopaedics & NEUROSURGERY

PATIENT - COMPLETE THIS SECTION

- Patient name: _____
- Date of Surgery: ◯ Right hip: _____ | ◯ Left hip: _____
- Type of Surgery: ◯ Right hip: _____ | ◯ Left hip: _____
- Postoperative Interval from Surgery:
  (for each side, choose one of the following: **N/A**, **6 weeks**, **1 year**, **2 year**, **>2 year**)
  ◯ Right hip: _____ | ◯ Left hip: _____

SECTION TO BE COMPLETED BY PHYSICAL THERAPIST

1. Patient Charnley Category:
   - ◯ A1: Unilateral with opposite hip normal
   - ◯ A2: Bilateral with satisfactory function of opposite hip
   - ◯ B: Unilateral other hip impaired _
   - ◯ C: Multiple arthritis or medical infirmity
2. Range of Motion:

MEASUREMENT	Right	Left
a. Flexion Contracture*	___	___
b. Flexion to**	___	___
c. Abduction @ 45° of flexion to	___	___
d. Adduction @ 45° of flexion to	___	___
e. External Rotation @ 45° of flexion to	___	___
f. Internal Rotation @ 45° of flexion to	___	___
g. IR with knee flexed to 90° ***	___	___

* Enter 0 if the leg is able to lie flat on the exam table.
** Do not push past 100 degrees before 1 year

***Do not perform this one until one year after surgery please

3. Gait:
   ◯ Normal ◯ Antalgic ◯ Trendelenburg ◯ Short Leg ◯ Other: _____
4. Trendelenburg Sign: ◯ Positive ◯ Negative
5. Active SLR painful? ◯ No ◯ Yes | Where? _____
6. Strength SLR (Grade 0-5): _____
7. Strength Abduction (Grade 0-5): _____
8. Leg Length: ◯ Equal ◯ Left short: _____ ◯ Right short: _____
9. Tender?: ◯ No ◯ Yes | Where? _____
10. Condition of incision: _____

Physical Therapist Signature: _____

Date: _____

PT Print Name: _____

Address: _____