**Lumbar spine protocols**

Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

I am in the process of updating the rehabilitation protocols for patients who underwent either lumbar discectomy/laminectomy or lumbar fusion and would like your input.

Please take a moment to answer the questions below.

I appreciate your time to fill this out!

Thanks

Kristel PT

**Questions pertaining to lumbar discectomy / laminectomy:**

1. Do you generally send your patients to PT after undergoing this procedure?

🞏 Yes 🞏 No

1. If yes, how many weeks post-op do you want them to start

🞏 0 – 2 weeks 🞏 2-4 weeks 🞏 4 - 6weeks 🞏 other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any restrictions / precautions you want to stress:
	1. Lifting restriction: 🞏 Yes 🞏 No

If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_lbs for\_\_\_\_\_\_\_\_\_\_\_\_ weeks

* 1. Twisting: 🞏 Yes 🞏 No
	2. Bending: 🞏 Yes 🞏 No
	3. Running: 🞏 Yes 🞏 No

If yes, for how many weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Recreational activities such as golf/tennis etc.

 🞏 Yes 🞏 No

 If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Other: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Do you give the patient any written instructions regarding return to normal activity / work post surgery?

🞏 Yes 🞏 No

1. If answered yes above, where can I find a copy?

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**Questions pertaining to lumbar fusion:**

1. Do you generally send your patients to PT after undergoing this procedure?
2. 🞏 Yes 🞏 No
3. If yes, how many weeks post-op do you want them to start?

🞏 0 – 2 weeks 🞏 2-4 weeks 🞏 4 - 6weeks 🞏 other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have them wear a brace after surgery?

🞏 Yes 🞏 No

If yes, for how many weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any restrictions / precautions you want to stress:
	1. Lifting restriction:

🞏 Yes 🞏 No

If yes: \_\_\_\_\_\_\_\_\_\_\_lbs for\_\_\_\_\_\_\_\_\_ weeks

* 1. Twisting: 🞏 Yes 🞏 No
	2. Bending: 🞏 Yes 🞏 No
	3. Running: 🞏 Yes 🞏 No

If yes, for how many weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Recreational activities such as golf/tennis etc.

🞏 Yes 🞏 No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Other: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Do you give the patient any written instructions regarding return to normal activity / work post surgery?
2. 🞏 Yes 🞏 No
3. If answered yes above, where can I find a copy?

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Any additional comments / feedback:

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