REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee Notification

Request for Family or Medical Leave must be made in writing, if practical, at least 30 days prior to the date the requested leave is to begin.

Name Ben Averyheart Date 4/25/2013

School Gwendolyn Brooks MS Position Industrial Tech

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I request a family or medical leave for one or more of the following reasons. I understand that a physician's certification and all required information must be submitted before this request is processed.

_____ Because of the birth of my child, or because of the placement of a child with me for adoption or foster care.

_____ In order to care for my spouse/child/parent who has a serious health condition.

__✓__ For a serious health condition that makes me unable to perform my job. THIS CONDITION ____ IS ✓ IS NOT WORK RELATED.

_____ Requested intermittent or reduced leave scheduled _____

Leave to start 4/9/2013 Expected return date Beginning of 2013-2014 school year

_____ I would like to use my sick/personal days
_____ I would not like to use my sick/personal days
_____ Original request for leave
__✓__ Request for extended leave

Employee Signature Benjamin Averyheart Date 4/25/2013

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LEAVE APPROVAL

Principal/Designee Signature _____ Date 4/29/13

05-02-13P12:56 RCVD

Superintendent Signature _____ Date _____

Board Secretary Signature _____ Date _____

Board President Signature _____ Date _____

04-26-13A11:29 RCVD

6850 West Centennial Drive
Tinley Park, IL 60477
(708) 429-3455
(708) 429-3422 fax

DANIEL WEBER, M.D.
Fellowship Trained
Hip and Knee Reconstruction
Sports Medicine/Arthroscopy

EDWARD JOY, M.D.
Fellowship Trained
Shoulder and Elbow Surgery

INTEGRITY ORTHOPEDICS
IntegrityOrthopedics.com

JAMES KRCIK, M.D.
Fellowship Trained
Pediatric and Adult Sports Medicine
Arthroscopy

19.Apr.2013
Patient's Name: Mr. Benjamin Averyheart

Phone # (708) 333-1736

Diagnosis:
V43.65 S/P Knee joint replacement
Condition: stable, improved; Location: left
V81.2 At first post-op visit a physical exam for VTE performed and documented
Condition: stable; Location: left

Procedures:
Total Knee Arthroplasty
Knee X-Ray; AP/lat/tunnel/sunrise

General Information:
• Walker or crutches should be used until able to progress to cane on advice of Physician or Therapist.
• Ice knee frequently with cryocuff or ice pack, up to 30 minutes 2-3 times a day.
• Change knee position at least once an hour, while awake, to avoid stiffness
• Home exercises should be performed 3x/day
Reminder for stair use:
• Upstairs - the nonoperative leg goes first, then the operative leg, lastly the crutches or cane
• Downstairs - the crutches or cane go first, then the operative leg, lastly the nonoperative leg

Rehabilitation:

0-3 weeks
Goals
1. Safe ambulation with walker, crutches or cane (level surface and stairs)
2. Range of motion 0-100 degrees
3. Independent transfers
Exercise
1. Quad sets- tighten knee muscles of out stretched leg by pushing the back of the knee into the bed, hold 5 seconds
2. Gluteal sets- squeeze buttocks together, hold 5 seconds
3. Ankle pumps- pump ankles to move feet back and forth
4. Heel slides- bend knee, sliding foot toward buttocks
5. Hip abduction- slide leg out to side keeping the knee straight
6. Knee flexion- sitting in firm chair, slide foot back bending knee as far as possible, hold 5 seconds

7. Stationary Bike - can begin at 2 weeks
8. Seated terminal knee extension with foot elevated on stool or pillow.

6+ weeks
Goals
1. Safe ambulation on uneven surfaces with straight cane
2. Safe ambulation without assistive device or gait deviation on level surface
3. Independent with all ADLs
4. Independent with advanced home exercise program
Exercise
1. Squats (as able)
2. Forward step ups (advance in 2 inch increments)
3. Forward step downs (advance in 2 inch increments)
4. Leg press

Discharge Criteria:
- Safe ambulation without assistive device
- Ascend and descend stairs independently
- Independent home exercise program
- Normal ADL function

Physical Therapy

Frequency: __ 1-2x/wk _X_ 3x/wk __5x/wk

Duration: __ 1-2 wks _X_ 3-4 wks

Daniel Weber, MD
Physician's Certification:
I certify/re-certify that the above patient care plan for Physical and/or Occupational Therapy is appropriate and necessary. That the services will be furnished while the patient is under my care and that the plan will be reviewed every 30 days or more often if patient's condition requires.