Below-knee amputation: transfer

Original independent practice. Time allowed: 45 minutes (5 minutes reading and 40 minutes writing). Assume that today's date is 3 November 2026. Mr Rokoduguni is transferring to inpatient rehabilitation today. You are a registered nurse on a surgical ward. Using the case notes, write a transfer letter to Ms Alesi Nacuqu, Rehabilitation Nurse, Inpatient Rehabilitation Unit, 24 Rehabilitation Road, SW1P 3BT, United Kingdom. Explain Mr Rokoduguni's current transfer assistance, residual limb care and rehabilitation needs following his below-knee amputation. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mr Napolioni Rokoduguni	☐	☐	☐
2. DOB: 20/08/1969 (57 yrs)	☐	☐	☐
3. Admitted 25/10/26; transfer to inpatient rehabilitation 03/11/26	☐	☐	☐
Social background			
4. Lives with wife in upstairs flat; no lift	☐	☐	☐
5. Wife supportive but unable to provide lifting assistance	☐	☐	☐
6. Worked as warehouse supervisor; independent mobility before injury	☐	☐	☐
7. Wants to resume gardening; anxious about returning home	☐	☐	☐
8. Wife discussed neighbour's marital problems during visit	☐	☐	☐
Medical history			
9. No diabetes or previous mobility limitation	☐	☐	☐
10. No known drug allergies	☐	☐	☐
11. Remote tonsillectomy; no ongoing problems	☐	☐	☐
25–29/10/26 — acute surgical course			
12. 25/10: machinery crush injury to L lower leg	☐	☐	☐
13. 26/10: L below-knee amputation; limb could not be salvaged	☐	☐	☐
14. Early postoperative vomiting resolved; now eating normally	☐	☐	☐
15. Temporary urinary retention resolved; catheter removed; voiding independently	☐	☐	☐
16. 29/10: surgical drain removed; no further drainage	☐	☐	☐
02/11/26 — surgical review			
17. Residual limb incision closed/dry; mild swelling; no redness/discharge	☐	☐	☐
18. New protective dressing applied; surgical review booked 06/11	☐	☐	☐
02/11/26 — surgical review			
19. Team: keep dressing intact until review; contact surgery sooner if wet/loose/soiled	☐	☐	☐
20. No prosthesis yet; compression garment not commenced	☐	☐	☐
03/11/26 — function and nursing care			
21. Wheelchair mobility on ward; needs help positioning chair for transfers	☐	☐	☐
22. Physiotherapy assessment: bed–chair transfers with slide board + 1 staff member	☐	☐	☐
23. No independent standing transfers; occasionally attempts transfer alone	☐	☐	☐
24. Incision discomfort minimal; intermittent non-painful phantom sensations explained	☐	☐	☐
25. R foot skin intact; patient understands need to protect remaining limb	☐	☐	☐
26. Alert, oriented; participates in therapy despite anxiety	☐	☐	☐
Transfer plan			
27. Continue stated transfer assistance; reinforce call bell use before moving	☐	☐	☐
28. Check dressing/surrounding skin daily; report ↑ redness, warmth, discharge or swelling to surgical team	☐	☐	☐
29. Continue physiotherapy/OT; request home-access assessment before discharge planning	☐	☐	☐
30. Prosthetic assessment when rehabilitation team considers him ready	☐	☐	☐
31. Wife requests involvement in rehabilitation goal-setting, with patient's consent	☐	☐	☐
32. Complained about another patient's snoring overnight	☐	☐	☐

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