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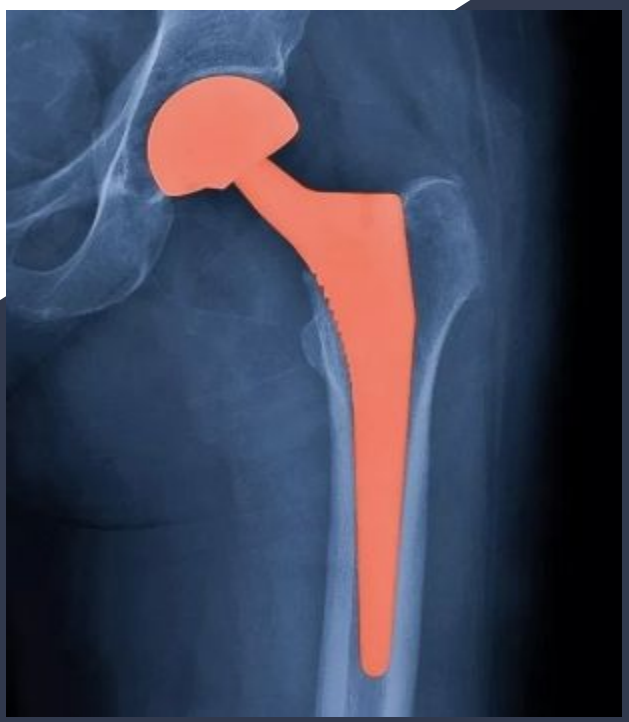
& Sports Medicine Specialists

Dr. Presley Swann

Your Hip Replacement Guide



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Types of Hip Replacements

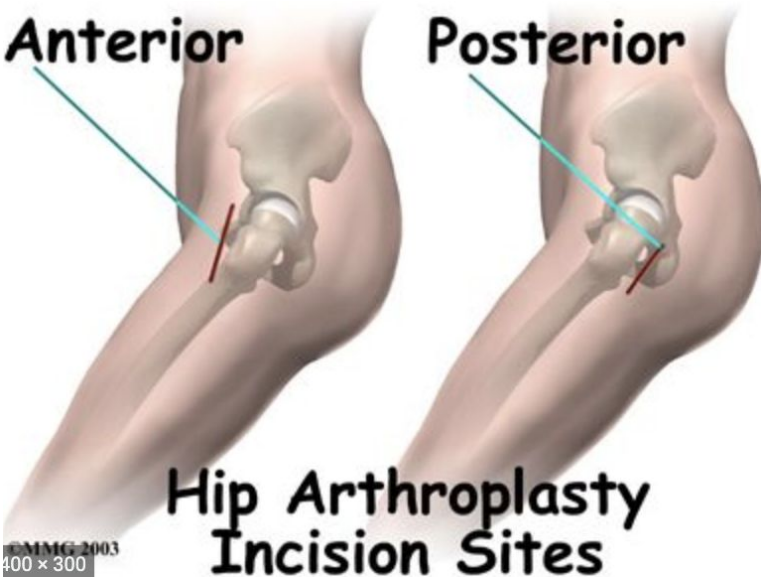
For more information on the types of knee replacements, visit our website
http://coloradokneeandhip.com

Direct Anterior Approach

Traditional total hip replacements have been made through a side incision or back of the hip incision. Direct anterior approach involves a 3-4 inch incision at the front of the hip that allows the muscles to be moved without having to detach tendons to replace the worn ball and socket. By not removing tendons, the hip can be more stable so post-op hip precautions can be minimized.

Mini-Posterior Approach

The mini-posterior hip replacement offers as small as an incision as the direct anterior hip approach, roughly around 3-4 inches. The difference is this approach is done through the posterior or back of the hip. The approach is an advancement of the traditional posterior approach, but unlike the traditional posterior, Dr. Swann does not have to cut abductor muscles which are used to provide hip stability. Both approaches offer excellent results, Dr. Swann will work with you to decide which approach will be best for you and your new hip!



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Risks of a hip replacement

Risks of Joint Replacement:

- Infection (<1%)
  - Weight.
  - Dental health is important. Obtain all dental work necessary prior to surgery. **No routine dental work or cleanings for 6 months after surgery unless absolutely necessary.** You will need antibiotics 1 hour before every dental procedure (even cleanings) lifetime. This precaution also applies to any other invasive medical procedure such as colonoscopy or urologic procedures. ALL medical professionals should be aware of your joint replacement. You may call us for antibiotic prescriptions.
  - Quit smoking to reduce risk of wound problems and infection
- Bleeding requiring transfusions
  - Risk is very low unless you are anemic (low blood count) prior to surgery.
- Blood clots
  - Risk is present with any operation of the legs.
  - May cause death in extremely rare cases (1/10,000) if blood clots travels from legs up to the lungs and blocks flow to the heart (pulmonary embolus)
  - Will be placed on aspirin (or Eliquis) 2x day for 1 month after surgery to minimize this risk.

- STIFFNESS
  - Success of surgery is dependent on how well you do your therapy!
  - The newly operated hip will want to scar down. If you allow this to happen you will not be able to bend or straighten your hip fully and will be painful the rest of your life! This cannot be fixed without another surgery and is not guaranteed to help.
  - The key is preventing the scar from developing during the 3 months after surgery.
  - I expect 90% of your preoperative range of motion back by 1 month (typically about 100-110 degrees of flexion) and full motion by 3 months.
- Dislocation
  - This is very rare, however this can occur with any approach that is used for Total Hip Replacement.
- Hardware Failure/Loosening

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Getting Ready for Surgery

Tasks

- Make sure you have some help at home to aid you with your activities of daily living.
- Most people take approximately 6-12 weeks off from their job depending on the type of job. However, some people will get back to work sooner if their job is not too labor intensive.
    - You should be in contact with your employer and bring any paperwork that needs to completed for time off prior to your surgery.
- We also recommend arranging your house to be as safe as possible to avoid falls.
    - If possible, avoiding stairs is helpful but is not mandatory. The therapist will teach you how to manage stairs before you leave the hospital.
- You will also be scheduled for a pre-op appointment with Dr. Swann's Physician Assistant, Caleb Jennings.
    - At this appointment he will go over the surgery with you, answer any questions that you may have and sign the consent for the operation.

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Surgery

7 days prior to operation

- At this time you will stop taking all blood thinning medications. This can be a long list of medications and if you have any questions, please don't hesitate to call. You will also go over this with the nursing staff before your surgery
- The most common blood thinning medications are as follows:
    - Aspirin
    - NSAIDs including but not limited to:
        - Ibuprofen
        - Advil
        - Aleve
        - Diclofenac
        - Celebrex (celecoxib)
        - Mobic (meloxicam)
    - Vitamin E
    - ****IT IS ESSENTIAL THAT YOUR PRIMARY CARE PROVIDER, PULMONOLOGIST, HEMATOLOGIST, AND/OR CARDIOLOGIST CLEAR YOU TO STOP TAKING OTHER BLOOD THINNERS.** These include but are not limited to:
        - Coumadin
        - Xarelto
        - Plavix
        - Eliquis
        - Pradaxa
            - These medications are used to treat a variety of conditions including a history of atrial fibrillation, a history of a heart attack/stroke, and/or a history of blood clots or pulmonary embolism.
    - **If you take these medications, special instructions will be given to you before your surgery.**

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Surgery

3 days prior to surgery

- At this time you will start using a special soap. This soap is called chlorhexidine also known as Hibiclens.
    - This soap removes unwanted bacteria that grows on your skin which helps decrease your risk of infection after your surgery.
- Directions for use:
    - You will use the soap when you shower **twice daily.**
        - You will shower normally with soap and water. Wash all the normal soap off of your body completely.
        - Turn the shower off.
        - Scrub your entire body with this soap (**other than your face**)
        - You will wait 3 minutes with the water off.
        - Afterwards, you will proceed with rinsing the soap off of your body completely.
            - After this, you will NOT use any regular soap on your body.
        - Turn the shower off and dry off as you normally would.
            - Make sure to use a clean towel after every shower.
- Some hospitals will give you special wipes for this. If this is the case, it is okay to use their instructions for the wipes.

3 days prior to surgery

- It is required that you change your sheets daily 3 days prior to surgery to help keep your body free of unwanted bacteria.

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Surgery

The Night Before Surgery

- The night before surgery, you will want to eat a well balanced meal.
    - After midnight, you will not be allowed to eat any food.
- You should take your medications as instructed the night before unless you are instructed otherwise by your primary care provider, the hospital staff, or Dr. Swann's team.
    - If you have any questions regarding your medications, please feel free to reach out to Dr. Swann's office or your primary care provider.
- You will also be given a special drink that will you will drink 4 hours prior to surgery. If you did not go to the hospital for your pre-op testing, you can substitute 10 oz of Gatorade. If you are a diabetic, you will not be given this drink.
- It is expected to be nervous and anxious before surgery.
    - You want to try to get to bed early and get a good night's rest before showing up the morning of surgery.

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THE DAY OF SURGERY

The morning of surgery

- Make sure that you do not eat anything the morning of your surgery. (You will hear people telling you to make sure you are “NPO”)
    - Depending on the hospital policy, some hospitals allow you to have water up until 4 hours prior to your surgery. Please check with the hospital and/or surgery center to verify this policy.
- You will be allowed to take certain medications the morning of surgery with a **small sip of water.** You will be contacted before surgery by someone from the hospital to tell you what medications to take and what medications not to take.
    - Some medications that typically are NOT taken the morning of surgery include ACEI and ARBs. These are medication that is used to help control your blood pressure. Some common medications include:
        - Lisinopril
        - Benazapril
        - Losartan
    - All medications decisions are made on a case-by-case basis and you will be instructed on which ones to take.

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THE DAY OF SURGERY

The morning of surgery

- You will show up in the pre-operative area at the designated facility.
- Timing:
    - Typically with joint replacement surgery, most hospitals would like you to show up 2 ½ hours prior to the scheduled surgery time.
- You will be checked in, after which a nurse will ask you questions in regards to allergies, what side of the body is undergoing surgery and start an IV access. These questions may seem redundant, but they are necessary for your safety.
- Anesthesia
    - You will then meet with an anesthesiologist.
    - They will discuss with you what type of anesthesia will be given and will have you sign their consent forms.
        - Typically with joint replacement, a spinal anesthetic is used which is very safe and effective.
            - Do not worry, you typically will not remember this part.
- Surgery
    - The surgery will typically take about 1 to 1.5 hour(s).
        - Please visit our website for a demonstration of your surgery
            - http://coloradokneeandhip.com.

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Inpatient vs. Outpatient

- Dr. Swann will decide if you are a candidate for an outpatient total joint replacement versus a one night stay total hip replacement
- The main goal is to make sure you are safe to discharge home on the same day or if you need a night in the hospital for further monitoring and observation
- There are multiple factors involved in this decision and he will do what he feels is safest for you

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Inpatient

- If the decision was made for a one night stay or if your surgery is done later in the day, you will typically spend 1 night in the hospital.
    - During this time, you will be given a private room on the Orthopedics floor.
    - There may be a “Hospitalist” or medical doctor that will come and see you during your stay.
    - You will participate in therapy the day of surgery as well as the day you leave.
        - The PT and OT will show you how to manage stairs and make sure you are safe for discharge home
    - You will have a case manager at the hospital who will help get all of the discharge planning ready for you including home health therapy, possibly a home health nurse and ensure that you have all the equipment needed for discharge.
- Please refer to the outpatient discharge instructions once you are discharged.

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Outpatient

GOALS:

First 2 weeks goals are pain control and swelling control which go hand in hand along with getting your ROM of the hip. You should rest with elevation and icing the hip most of the day. Do your exercises and then elevate and ice. If you are up walking around a lot, your hip will swell which causes pain and problems getting your motion. You will be discharged home and home PT will begin therapy the next day. Your first night is just about getting comfortable and getting sleep. The goals of pain control are comfortable but not lack of pain.

TIME LINE OF YOUR SURGERY DAY

1) **Show up on time to pre op area where you will be premedicated, IV placed and consent signed**
2) **Dr. Swann will meet you and sign your side to be done**
3) **You will be brought to the OR where you will receive a spinal anesthetic and block to the hip**
4) **Surgery takes around an 1 hour to 1 .5 hours**
5) **You will be brought to PACU and then transferred to a Room and will have PT see you**
6) **Your goals are 100 feet ambulation safely with walker**
7) **You will rest for 2-3 hours and all paperwork completed prior to discharge**
8) **Physical therapy will assess again with stairs and then you can discharge home (this is only if needed - some patients are able discharge after the 1st physical therapy session)**
9) **You will go home and simply rest**
10) **Therapy will see you within a few days at Home. This will be set up for you.**

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Outpatient

PAIN CONTROL

DO NOT WAIT UNTIL YOUR PAIN IS SEVERE. Give your nurse some lead time to get you the medications you need, as they are also taking care of other patients. You should be taking scheduled Tylenol, and Meloxicam based on insurance coverage. Only if still painful then take the narcotic below.

- Oral Narcotics
  - Oxycodone - strong, immediate relief every 3-6 hours
  - Ultram 50mg- This medication is for moderate pain. This medication should be taken as prescribed and should not be taken if you have a history of epilepsy. This medication should be scheduled as well.
- Anti-inflammatory
  - Meloxicam- This medication is in the class of NSAIDs and should only be taken if okay by your medical doctors. This medication is taken for 2 weeks scheduled.
- Muscle Relaxer:
  - Robaxin- This medication can be taken three times daily for muscle spasms.
- Pain medication:
  - Acetaminophen (Tylenol) - This medication should be take scheduled. You should take 1000 mg every 8 hours. You should not take this medication if you have significant liver disease.

NAUSEA CONTROL

All of your control options are listed below.

- Scopolamine Patch
  - 1 patch behind the ear the night before surgery, change once every 3 days. If not having any feeling of N/V then ok to stop the scopolamine patches once you are home
- Zofran
  - This medication should only be taken as needed for nausea and/or vomiting which is a common side effect of pain medication and anesthesia.

CONSTIPATION

- Constipation is a result of pain meds and dehydration.
- Senna-S 2 tabs p.o. q.h.s. *unless* BMs are regular. Script is called in to pharmacy prior to surgery.
- No patient should go more than 5 days without a BM.
- Hydrate, hydrate, hydrate – 1 gallon of water daily.
- Should drink apple juice or prune juice if having trouble.
- Dulcolax suppositories p.r.n.
- MiraLAX p.o. to effect. Take as directed on label.
- Call/email us if the patient is having problems.

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Outpatient

PREVENTING BLOOD CLOTS (DVT-Deep Venous Thrombosis)

- Aspirin
  - Aspirin 81 mg 2x day for 4 weeks unless you are at increased risk for blood clots, in which case you will be placed on Eliquis.
- Compression devices
  - Placed on the lower legs while in bed at the hospital
  - Intermittently squeezes your legs to propel the blood in your legs back to your heart.
  - May remove when out of bed, but replace them when you get back in bed.
- Ankle pumps
  - At least 10 repetitions every hour.
  - The muscle contractions also squeeze the blood back up to your heart.

BATHING

- You will sponge bathe for the first 2 days after surgery while the dressing is on.
- You may shower 48 hours after surgery.
- You may shower after the bandage is removed with soap and water without scrubbing at incision.

WOUND CARE

- Typically, you will have compression stockings for swelling. These should stay on for a 2 weeks to help with swelling and removed periodically throughout the day.
  - After post op day two, you may shower.
  - You will have a dressing that is white overlying the incision. It is okay to shower with this on.
    - If this starts to come off or gets wet, you may remove this dressing but make sure you leave the Dermabond (glue) mesh in place. This will stay on until follow up. It is okay to shower with this on and have water run over this.
  - If you have staples, keep the staples clean and dry. It is okay to shower on post op day two, however you should wrap the incision with plastic wrap or a special covering that can be purchased at multiple drug retail stores
- Sometimes, we use a wound vac system called a PICO dressing. This dressing will stay on for 1 week. You can not get this dressing wet as it has an electronic component to it. This will die at the 1 week mark. You should then remove the dressing and place a dressing that you will get from the hospital which is waterproof. It is okay to shower at that time.

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Outpatient

ACTIVITY WHEN YOU GET HOME:

- Your main goals of home therapy:
  - Obtaining **FULL EXTENSION** of your hip
  - **WALKING, and Stationary Bike is all you need for rehab of a hip**
  - Use your **other hip** as a guide to the motion you should eventually be getting
- You should be sitting up for all meals, allowing your hip to bend as best you can during that time, as you do during your therapy exercises.
- Use your walker or crutches for ambulating when you are up for best stability and follow the therapist's instructions for their proper use, especially when getting up and down and transferring.
  - Do not advance yourself to the use of a cane unless the therapist or doctor tells you to.
  - Do not walk hanging onto furniture for stability, as this can lead to bad falls.
- If you have to negotiate stairs, **always** use the handrail and follow the instructions given to you by your therapist.
- Walking for brief periods is good for you. In general, 10 minutes at a time is plenty, and stay on smooth predictable surfaces.
- **Rest is very important, as your energy level will be low.** You will have a lower blood count, the surgery is stressful to your body, the medications make you feel tired, and your endurance will not be good at first. Get off your feet, lie down, and rest as much as possible when you don't have any reason to be up.
- Obviously, if any sudden changes in your energy level occur with other symptoms such as chest pain, sudden shortness of breath, dizziness, etc., that is not normal and you should contact our office.
- It is **common** to run a low-grade fever such as 99.5-100 degrees in the evenings. This is not worrisome as long as no other symptoms occur, such as weakness, chills, or aching, with or without hip pain.
- **Any sudden increase in pain, pressure, tightness, or swelling in the calf should be reported to our office promptly, as these can be signs of blood clots or thrombosis in the deep veins of the leg.**

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Outpatient

CARE AND APPEARANCE OF YOUR HIP:

- When you get home, you should **keep your wound clean and dry**. Gauze can be purchased at your local drug store. You should avoid applying any ointments, salves, or lotions of any kind.
- Shower is ok
    - When you shower, sit on a stool for support. **Do not** try to stand or balance mostly on 1 foot.
    - **Do not** immerse your hip under water in the tub for any reason. (Hot tubs are **off limits** for 6 weeks after surgery.)

- After surgery, your hip will swell and look puffy. In general, this should improve each day. It tends to get worse the more you exercise and definitely the more you are up.
- The incision should be dry and not have drainage coming from it except in small spots by the staples. Any active bleeding or worrisome drainage should be reported to our office.
- The skin around the incision and the hip may be light red and slightly warm. There may also be bruising on the shin and hip, especially in the back of the leg, that may get somewhat worse over time during the first couple of weeks.
    - **Any intense redness or heat with new pain, fever, swelling, or stiffness should be reported.**
- **Icing of your hip is very helpful to reduce swelling and pain.** You may use the ice packs you used in the hospital, commercial ice packs, or a large Ziploc or tied plastic bag filled with ice draped over the hip. Icing the shin and thigh can also be helpful for comfort and swelling, especially if there is bruising.
    - Icing should be done after exercises and throughout the day to treat swelling and soothe the hip. Do not apply ice directly to the skin. Icing should be done for no longer than 20 minutes at a time. Note excessive lingering of redness in the skin, which can be an indication you are icing too long or causing frostbite to the skin.

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Home Exercise Program

REHABILITATION

Surgery was half the battle. The other half starts now! It will begin with aggressive physical therapy. The main goals of physical therapy are:

- **WALKING**
  - You cannot walk normally without the hip straight.
- Minimize the amount of time your leg is hanging down, dependent to gravity, when you are out of bed. You should spend no more than 45 minutes with the leg down. If you are sitting in a chair, prop it up to minimize swelling in your hip and ankle.
- **DO NOT** fall behind with pain control. Pain will inhibit you from maximizing your rehabilitation and may compromise your range of motion and outcome!

Precautions: These should be followed for 3 months from the day of surgery.

- Anterior Hip Precautions:
  - No forceful hip extension
  - No external rotation
- Posterior Hip Precautions:
  - Do not bend your hip past 90 degrees while standing, sitting or lying.
  - Do not cross your legs. This includes while you are sitting, walking,standing or sleeping on your back or side.

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Frequently Asked Questions

When can I drive?
Driving can usually resume at 8 weeks after surgery. You must be off all narcotics, be quick and strong enough to step on the brake (especially if you were operated on your right leg!). You must be able to protect yourself and others. If this is the left leg, most people can drive at about the 4 week mark.

How long will I be out of work?
It depends on what type of work you do. You will need about 6-12 weeks on average. If you have a sedentary job, you may return sooner than others who need to be on their feet constantly. This can be discussed at your 2-week appointment.

When can I fly in an airplane?
Flying may resume at 4-6 days. Try to sit in an aisle seat and make arrangements for luggage and connections. Blood clots are the biggest concern, so you **MUST** do ankle pumps every 15 minutes, and walk about the plane every 30 minutes.

******How long after surgery will I need to have antibiotic prophylaxis prior to dental work or any other invasive procedure (i.e. colonoscopy, urologic, or upper GI procedures)?***
This will be needed for the rest of your life. I ask that you DO NOT have any dental work for at least the first 6 months following your surgery. You should be given Amoxicillin 2g 30 minutes before the procedure or another antibiotic if you are allergic to penicillin. **********

When can I shower?
You may shower on post op day 2. You may shower with the dressing in place. Use soap and water without scrubbing the incision.

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Physical Therapy and Nursing Guide for Total Hip Arthroplasty

WOUND CARE

- Almost all wounds are now glued shut with Dermabond and absorbable sutures underneath. These wounds are usually water tight, but if there is drainage they are clearly not water tight yet.
- The wound is typically sealed in 7-10 days. May use soap and water in the shower to clean the wound without scrubbing the incision itself and pat the wound dry.
- Once the wound is no longer draining, it does not need to be covered.
- Call or email if the wound does not look healed in 10 days.
- You may see some black scabs or glue residue. This is normal.
- By 4 weeks postop, encourage the use of moisturizer with Vitamin E around the wound to help keep it healthy looking and supple.

IF THERE ARE STAPLES (RARELY)…

- Clean staples daily with ChloraPrep or alcohol swabs.
- Do not get the incision wet in the shower. They will be removed at your first post-operative appointment.

AFTER STAPLES ARE REMOVED

- May get knee wet in shower 24 hours after staples are removed.
- May bathe in tub at 3 weeks.
- **CALL ME with any worsening wound redness, drainage, swelling, or increased pain or fevers.**

DVT PROPHYLAXIS

- Aspirin 81 mg 2x day for 1 month Aspirin unless you are at increased risk for blood clots, in which case you will be placed on Eliquis 2.5mg.

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IF THERE ARE STAPLES (RARELY)…

- Clean staples daily with ChloraPrep or alcohol swabs.
- Do not get the incision wet in the shower. Use BLUE RUBBER SHOWER SLEEVE until staples are removed.
- They will be removed at your first post-operative appointment.

CALL ME with any worsening wound redness, drainage, swelling, or increased pain or fevers.

DVT PROPHYLAXIS

- Aspirin 81 mg 2x day for 1 month Aspirin unless you are at increased risk for blood clots, in which case you will be placed on Eliquis 2.5mg.

PAIN CONTROL

- Most patients are sent home with:
  - Oxycodone 5 mg 1-2 tablets p.o. q 4-6h p.r.n.
  - Anti-inflammatory (NSAIDS) for swelling (Meloxicam 15mg or Celebrex 200mg BID)
    - Most patients are prescribed Meloxicam 15mg daily
    - If unable to tolerate NSAIDs, Celebrex 200mg BID will be given instead.
    - After these two weeks are up, we do not want you to have NSAIDs so that the parts can grow into your bone.
  - Tylenol and Ultram
  - No NSAIDS in those with renal insufficiency or allergy.
- Notify us if pain control is inadequate.

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Physical Therapy and Nursing Guide for Total Hip Arthroplasty

NAUSEA CONTROL

- Hydroxyzine HCL 50mg – take 1 tablet p.o. Q6H PRN n/v. Script is sent in to patient's pharmacy 1 week prior to surgery.
- Take pain meds on full stomach if possible.
- If pain meds are seen to directly cause nausea, then please call/email us so that we can adjust pain meds for them.

CONSTIPATION PREVENTION

- Constipation is a result of pain meds and dehydration.
- Senna-S 2 tabs p.o. q.h.s. *unless* BMs are regular. Script is sent to pharmacy prior to surgery.
- No patient should go more than 5 days without a BM.
- Hydrate, hydrate, hydrate – 1 gallon of water daily.
- Should drink apple juice or prune juice if having trouble.
- Dulcolax suppositories p.r.n.
- MiraLAX p.o. to effect. Take as directed on label.
- Call/email us if the patient is having problems.

LEG SWELLING

- Goal the first 2 weeks postop is to control swelling.
- If you control swelling, you control pain, improve range of motion, and decrease side effects from narcotics. VERY IMPORTANT and PREVENTABLE.
- **MINIMIZE LEG DEPENDENT (TO GRAVITY) TIME TO 45-60 MINUTES AT A TIME**.
- Keep leg up whenever possible, e.g. eating a meal, watching TV).
- Encourage icing with Cryocuff/Vasutherm/GameReady (instruct on use) every 2-3 hours for the first 2 weeks.
    - Apply Cryocuff on hip with the bladder empty then fill with ice bucket to allow compression.
    - Remove after 30 minutes since it will be warm by then. Do not keep it on beyond that or overnight since will be a heat pack then.
    - Recharge and reapply in 2-3 hours while awake.
- They should never push PT stretches to the point of severe pain as that will cause more swelling and will set them back.

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Physical Therapy and Nursing Guide for Total Hip Arthroplasty

IDENTIFYING DVT

Sudden increase in swelling after little activity could be a sign of a **DVT**.

- HOMAN's sign is NOT reliable and should not be used as that may propagate the DVT.
- *IF THEY ALSO HAVE SHORTNESS OF BREATH OR CHEST PAIN THEY MAY HAVE A **PULMONARY EMBOLUS**! CALL ME or advise going to the ER.*
- They will need an ultrasound to rule out the DVT. If it is positive, they will simply need Coumadin for 3 months. If they have a PE, they will need 6 months of Coumadin.
- The initial treatment is elevation to minimize the pain of the swelling and to make sure they are therapeutic on Coumadin (Goal INR 1.5-2.5).

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Physical Therapy and Nursing Guide for Total Hip Arthroplasty

PHYSICAL THERAPY (5x/week x 2 weeks then 3x/week x 1 week)

- Must be seen within 48 hours of discharge
  - Most patients are discharged home by Tuesday or Wednesday
  - Please arrange to start therapy day after discharge
- Perform home safety evaluation and recommendations

ROM

- ROM measurements are relative
  - I do not care about ROM hip in the first 2 weeks. Stationary Bike is great for ease of ROM hip
  - Hip precautions both anterior and posterior
  - Ok to try Figure-4 position to tie shoes
- Goals:
  - Pain free ambulation by 2 weeks without gait aids

- **NEVER PERFORM PASSIVE ROM ON PATIENT!**
- NEVER HAVE THE PATIENT PUSH THEMSELVES TO THE POINT OF EXTREME PAIN!
  - They will swell if they do.
  - It will set them back if they swell.

STRENGTHENING

- Quad sets
  - Active hip extension
  - Straight leg raises
- Hamstring/Glute sets

GAIT

- Gait training with walker
  - May graduate to a cane only under supervision of physical therapist.
- Stairs
  - “Up with the good, down with the bad”
  - Progress to reciprocating steps

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Contact Information

Welcome to Advanced Orthopedic and Sports Medicine. Below, please find the names and contact information of your Orthopedic Care Team. If at any time you have questions or concerns, please feel free to utilize the direct numbers and/or email addresses listed.
When calling, you may reach a voicemail box where messages are checked daily and typically addressed within 24 business hours. If you have a question or concern that needs immediate attention or cannot be left on voicemail, please call our main line at (303) 344-9090. You may also utilize our mobile medical colleague Dispatch Health at (303) 500-1518 for more immediate attention.
Any emergent or life-threatening issue will require visiting the emergency department.
We make every effort to address inquiries left on voicemail or email within 24 business hours.

Thank you for allowing us to participate in your care as we strive to help you BE ACTIVE.

Your Orthopedic Care Team

TITLE	**CONTACT**	**PHONE/EMAIL**
MEDICAL ASSISTANT	Jennifer Jadick	303-344-9090 Ext. 3027 jennifer.jadick@occ-ortho.com
SURGERY SCHEDULER	Randalyn Kershner	720-974-5210 randalyn.kershner@occ-ortho.com
PHYSICAL THERAPIST		303-214-4595
BRACING/EQUIPMENT		303-214-4593
BILLING		303-214-4594
MEDICAL RECORDS		720-859-4031
FAX		303-344-1922