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Week-by-Week Recovery

Your guide after total knee replacement

From Adam J. Cien, DO

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A note from Dr. Cien

Recovery from a knee replacement is not what most patients expect. The surgery itself takes one to two hours. The recovery takes 6 to 12 months, with continued gains out to two years. That comes out to roughly 3,000 hours of recovery work after a 1-to-2-hour operation. How you use those hours is what this guide is about.

You may have been told that the harder you push early, the faster you heal. That is not how a knee replacement works. The knee swells, and swelling is what limits range of motion and drives pain. Push too hard in week 1 and you add to the swelling — which slows everything down. The protocol in this guide does the opposite. It is slower at the start and faster at the finish.

My rehab plan follows the work of Dr. Andrew Wickline, an orthopedic surgeon whose book *Less Swelling, Less Pain* changed how a lot of us think about the first few weeks. Independent research from major orthopedic centers has since shown that patients on this kind of protocol use less pain medicine, have shorter hospital stays, and reach the same long-term outcomes as patients on the older aggressive approach.

Two more things before you start. First, this is not a recovery you do alone — you will want a **recovery coach** at home; we will cover who and why in a few pages. Second, read this guide once before surgery, then come back to the page that matches your week. If something does not match what you are feeling, call us.

— Dr. Cien

How recovery actually works

Three things are happening inside your knee in the first few weeks. Tissues are healing. Swelling is building, peaking, and slowly draining. Muscles are waking up. Each of these needs a different kind of attention, and they happen on their own schedule — not yours.

Three things matter most

Ice and elevation. Cold and gravity together do more for your knee in the first two weeks than any exercise will. Ice constricts blood vessels and slows the inflammation. Elevation lets fluid drain out of the joint instead of pooling in it. The goal: **40 minutes of every waking hour,** for the first 10 to 14 days. When you elevate, get your **toes above your nose** — that is high enough for gravity to do its job.

Compression. You will wear a light compression sleeve called **EdemaWear** from foot to thigh, day and night, for the first 4 to 6 weeks. It applies gentle pressure that helps your lymphatic system clear the swelling that ice and elevation cannot reach. It is a third tool that works alongside the other two.

Frequent micro-walks. Walking is the one active thing your knee does well in week 1. Not far, not fast — just **frequent.** 5 to 10 steps every hour is the right dose. More than that adds swelling and sets you back.

Where this approach comes from

The slow-rehab framework I use was developed by Dr. Andrew Wickline, an orthopedic surgeon who has spent years measuring what actually helps recovery and what gets in its way. His book *Less Swelling, Less Pain* makes the case — with the data to back it up — that aggressive early therapy increases swelling and prolongs recovery. A more recent study of over 15,000 knee replacements at a major orthopedic center confirmed that patients on this kind of "quiet knee" protocol use less pain medicine, leave the hospital sooner, and reach the same long-term outcomes. That is the approach I follow with you.

Two restrictions for the first 6 weeks

Your new knee is strong from day one, but the soft tissue around it needs time to heal into place. Two things to avoid until 6 weeks:

- **No twisting or pivoting on the operated leg.** When you turn, plant your foot, then move your whole body. Do not swivel on the surgical knee.
- **No kneeling or deep squatting.** Both stress the front of the joint where the incision is healing. Use a long-handled tool to pick things up off the floor for now.

★ Use your walker for up to 6 weeks

I encourage the use of the walker or cane in your hands through week 6. It protects your knee from a stumble at exactly the wrong moment, and it lets your gait correct itself naturally. Some patients feel ready to step down to a cane earlier — that is okay with me **if** your therapist agrees and your body agrees. The earliest anyone should step down is after a full week with the walker, then at least another week with the cane before going aid-free. If you start to limp, feel unsteady, or notice the knee swelling more, go back to the walker. A small setback now is much easier than a big one.

Before surgery — the long ramp

How recovery goes is largely decided before you ever come to the hospital. Patients who are stronger, lighter, less inflamed, and better prepared walk out of the operating room with a head start. The list below is what I want you doing in the weeks leading up to surgery.

6 to 8 weeks before — set the stage

- **Get your pre-op labs and clearances done.** Bloodwork, EKG, and a chest x-ray. We use the results to fix small things now (low iron, vitamin D, sugar control) so they do not become problems later.
- **Walk through your home with fresh eyes.** Loose rugs, low chairs, narrow doorways, and stairs without rails are the most common trip hazards. Fix what you can; add grab bars in the bathroom if you do not have them.
- **Confirm your equipment.** Walker, raised toilet seat, shower chair, ice machine if you have one. The **Brief Patient Guide** lists everything you will want at home.
- **Catch up on vaccinations** (flu, COVID, RSV, shingles as appropriate). Surgery is not the time to come down with something.

4 to 6 weeks before — change how you live

- **Choose a recovery coach.** A spouse, adult child, sibling, or close friend who will be with you most of the time for the first two weeks. Not optional. The next page explains why.
- **Switch to an anti-inflammatory diet.** Mediterranean-style — lots of vegetables, fruits, fish, olive oil, whole grains; less red meat, less sugar, less processed food. Bodies that are less inflamed going in swell less coming out.
- **Cut salt.** No added salt at the table; read labels. Sodium pulls water into your tissues — exactly what we do not want before a surgery that swells.
- **Limit alcohol to one drink a day** and stop tobacco use entirely. Both interfere with healing.
- **Move every day.** Walk, bike, swim, or use an elliptical or rowing machine for 15 to 30 minutes. Pain in the bad knee is fine to work through within reason — your goal is to keep the rest of your body strong.

1 to 2 weeks before — finish strong

- **Meet with your physical therapist.** They will walk you through the exercises and stair coordination you will use after surgery. Practicing once with a real knee makes the post-op version much easier.
- **Pick up every prescription.** See **Your Medications** — you want everything sitting on the counter the day before surgery.

- **Do your skin prep on schedule.** Mupirocin, chlorhexidine mouthwash, and Hibiclens shower routine. See **Preparing Your Skin** for the day-by-day.
- **Stock the kitchen** with the kind of food you want to be eating when you are tired and on pain medicine — easy, nutritious, no shopping required.

Your recovery team

Two things make the biggest difference in how the first month goes. Neither is a medicine, neither is a piece of equipment, and neither happens in my office. Both happen at home. I want you to set them up now.

A recovery coach

Pick someone — a spouse, an adult child, a sibling, a close friend — to be with you most of the time for the first two weeks. This is not the same as someone driving you home and checking in. The coach is an active role.

- **They watch the clock.** The ice/elevation cycles, the hourly exercises, the step cap — these are easy to skip when you are tired. Your coach makes sure they happen anyway.
- **They are your second set of eyes on the incision.** Daily check. If something looks different from yesterday, you will hear about it before you would have noticed.
- **They normalize the ups and downs.** Days 3 to 5 are usually rough — the swelling peaks and the anesthesia is fully gone. Day 7 might feel great; day 9 might feel worse than day 3. Your coach hearing this from me makes it less alarming when it happens.
- **They help you make calls.** When something is off, the coach can call us while you stay off your feet. It also helps to have someone who heard the same instructions you did.

A recovery diary

A simple daily log is one of the most useful tools I can give you. It takes about five minutes a day and it does two things: it keeps you accountable to the protocol, and it surfaces problems before you would have thought to call us.

Each day, jot down:

- **Hourly checklist done?** Ice, elevation, the four hourly exercises (Week 1 page).
- **Step count.** A phone or fitness tracker is easiest.
- **Pain — best and worst of the day** on a 0-10 scale.
- **Pain medicines used.** Especially the count of any narcotic doses.
- **Sleep hours and where you slept** (bed, recliner, couch).
- **How the swelling looks.** Same as yesterday, more, less?
- **Best and worst part of the day.** One sentence each.

The diary is your early warning system

Most complications announce themselves before they become serious. Pain that creeps up day over day. Swelling that stops improving. A leg that gets harder, not softer. Patients who keep a diary catch these patterns several days earlier than patients who try to remember how they felt yesterday. When you call us, the first thing we ask is "how is it different from yesterday?" — and the diary is how you answer.

A sample day in your diary

To make this concrete, here is what a typical day 5 entry might look like. Day 5 is usually one of the harder days — swelling is peaking, the early adrenaline has worn off, and patients sometimes wonder if something is wrong. Most of the time, nothing is wrong; this is the protocol working through the predictable spike.

Day 5 — Wednesday

- **Hourly routine:** Yes — missed 2 hours when I napped 1 to 3 PM.
- **Heel hangs:** 3 sessions of 5 minutes. Knee got straighter by the third one.
- **Step count:** 612 (cap is 750).
- **Best pain today:** 4 out of 10 — this morning, right after a 40-minute ice.
- **Worst pain today:** 8 out of 10 — around 7 PM, before my next dose was due.
- **Pain medicines:** 2 Norco, 4 Tylenol, 2 Celebrex, all on schedule.
- **Sleep last night:** 5.5 hours, in the recliner.
- **Swelling:** About the same as yesterday. Maybe a little more in the calf.
- **Bowel movement:** Yes, this morning.
- **Best part of the day:** Walked to the kitchen and back without holding onto walls.
- **Worst part of the day:** Leg felt very tight after dinner. Iced and elevated for an hour and it eased.

What this entry tells me

A few things stand out when I read this. The 8 out of 10 pain spike fits the predictable pattern — pre-dose, after a long-ish day. Nothing alarming on its own. The slight calf increase is worth tracking, but on its own — without a hard or very tight leg, and with both calves looking similar — it is not a DVT flag. The bowel movement question is answered. The patient is under the step cap. And the worst part of the day was managed with the protocol itself.

If this same entry showed a worst pain of 10 unrelieved by medicine, a calf that felt hard, or no bowel movement five days in — those are the patterns that turn into phone calls. The diary makes them visible early.

What if my days look nothing like this?

Your diary will not match this one. Some patients hit their step cap most days; some never come close. Some sleep in the bed by night 3; some stay in the recliner two weeks. What matters is your shape over time — less swelling, more motion, fewer pain medicines week by week. The diary is how we see your shape clearly.

The first 72 hours after surgery

From the moment you leave the recovery room to the morning of day 3, the experience can feel a little disorienting. Pain comes and goes on its own schedule, the swelling is just starting, and you may not know what is normal. Here is what is actually happening — so the patterns make sense as you live through them.

Day 0 — surgery day

- **You may go home the same day** or stay overnight. Most patients go home.
- **Pain is often surprisingly low.** The anesthesia and any nerve block are still working. This is not how the next few days will feel — do not let it lead you to skip doses.
- **Start ice and elevation as soon as you are home.** Toes above your nose, 40 minutes of every waking hour.
- **Sip fluids and eat lightly.** Appetite is often poor; that is fine. Hydration matters more than calories today.

Day 1 — the anesthesia wears off

The biggest pain transition happens **24 to 48 hours after surgery.** The nerve block fades. The general anesthesia clears. The pain you wake up with may be the highest you feel during the whole recovery. This is not a setback — it is the predictable curve. **Stay ahead of it** with your scheduled medicines. Do not wait for pain to spike before the next dose. The hourly routine starts today; your coach helps you set timers.

Day 2 — settle into the protocol

- **Hourly routine in full swing —** ankle pumps, knee bends, knee straightenings, 5 to 10 steps with the walker.
- **EdemaWear on** whenever you are not in the shower.
- **Diary entry tonight.** Best pain, worst pain, what you took, how you slept. Even a short one.

Day 3 — swelling builds

The knee may look bigger and feel heavier than day 1. That is the swelling peak starting. Day 3 through day 5 is when ice, elevation, and compression earn their keep. Forty minutes of every hour. Toes above your nose. EdemaWear day and night.

★ The pain dip-then-spike is normal

Many patients feel relatively good on day 0 and day 1, when the anesthesia and nerve block are still working — then significantly worse from day 2 through day 5 as the medicine clears and swelling peaks. This is expected. If your day 4 feels harder than your day 1, it does not mean something is wrong. It means the medicine is gone and you are in the part of recovery where the work happens.

Week 1 — Heal

Your only job this week is to let the knee heal. Not stretch it. Not strengthen it. Heal it. This week is where the protocol earns its results — and where most patients are tempted to do too much.

Every waking hour, do this short routine

- **10 ankle pumps** (point and flex your foot).
- **10 gentle knee bends** (seated heel slides — slide your heel toward you, then back out).
- **10 knee straightenings** (tighten your quad and press the back of the knee down, hold a count).
- **Walk 5 to 10 steps** with the walker.

Two or three minutes total. Set a timer if you need to. Do not skip even when you feel fine — the hourly rhythm is what keeps the swelling moving.

The rest of every hour — ice, elevation, compression

- **Ice and elevate 40 minutes of every hour,** for the first 10 to 14 days. Toes above your nose. An ice pack or ice machine on the knee.
- **Wear your EdemaWear sleeve** whenever you are not in the shower. Day and night.
- **Heel hangs three times today, 5 minutes each.** Lie on a couch or bed with your heel propped on a small stack of towels or a footrest, knee straight, calf and back of the knee unsupported. Let gravity slowly straighten the knee. This is one of the most important exercises for getting extension back.

Your step ceiling this week: 750 steps a day

That is a ceiling, not a goal. If you hit 400 and feel tired, stop. The walking is to keep blood flowing, not to build mileage.

★ Call us this week if you notice

- **Pain above 7 out of 10** that is not relieved by ice, elevation, and your medicines.
- **Swelling that is not improving** after 24 to 48 hours of consistent ice, elevation, and compression.
- **A leg that feels hard or very tight,** especially if one calf is much more swollen than the other.
- **Fever above 101.5°F** or shaking chills.
- **Drainage from the incision** that soaks through the dressing, or any opening of the incision.
- **No bowel movement by day 5 after surgery.**

Living at home that first week

A few practical things that will make the first week easier. None of these are clinical decisions — they are the things patients always wish they had known on day 2.

Where and how to sleep

- **A recliner is often the best place the first week.** It lets you elevate without rolling onto the surgical leg, and getting in and out is easier than a bed.
- **A bed is fine too.** Use pillows under your **calf** — not under your knee. A pillow under the knee keeps the joint bent, and we are working hard to get it fully straight.
- **Side sleeping is OK after a few days,** on the non-operated side, with a pillow between your knees to keep the operated leg supported and aligned.
- **Expect broken sleep.** Five to six hours, in pieces, is the typical first-week pattern. It will improve.

Showering

- **You can shower once the incision is dry** and any draining dressing has been removed — usually 48 to 72 hours after surgery. We will confirm at your discharge visit.
- **Let warm water run over the incision.** Do not scrub it, do not soak it. Pat dry with a clean towel.
- **No baths, hot tubs, swimming,** or sitting in standing water until cleared — usually 4 to 6 weeks.
- **A shower chair and handheld showerhead** make week 1 dramatically easier and safer.

The bathroom — and constipation

Constipation is the most common predictable side effect of surgery and narcotic pain medicine. It is much easier to prevent than to fix. Plan for it from day 1.

- **A raised toilet seat** keeps you out of a deep squat. Use it for the full 6 weeks.
- **Drink 8 to 10 glasses of water a day.** Hydration helps swelling drain and prevents constipation.
- **Start MiraLAX or Senna on day 1.** Most patients need a daily dose for the first 1 to 2 weeks. Do not wait until you are uncomfortable.
- **No bowel movement by day 5?** Call us before it becomes an emergency.

Getting dressed and eating

- **Loose, easy clothing.** Sweatpants, stretchy pants, oversized shorts for the first few weeks.
- **A long-handled grabber** for socks, shoes, and anything you drop. You cannot bend down to get it.
- **Slip-on shoes with backs.** No flip-flops, no shoes without backs — both are fall risks.

- **Protein helps healing.** Eggs, chicken, fish, Greek yogurt, beans. Appetite often dips for the first few days; eat what you can.

Week 2 — Start to move

Outpatient physical therapy starts somewhere in this window — usually between days 5 and 10 after surgery. We wait this long on purpose. Starting PT before the early swelling has settled is how patients end up sore, stiff, and frustrated. Starting a few days later means your first session is productive instead of painful.

Your first PT visit

Your therapist will check three things on day one: how far you can bend the knee (flexion), how straight you can make it (extension), and how your gait looks with the walker. The exercises stay gentle — straight-leg raises, isometric quad sets, ankle pumps, gentle bending. No aggressive stretching, no resistance, no machines. The hourly routine from week 1 continues this week.

Why we wait on PT

Wickline's research compared patients who started PT in the first three days versus patients who waited five to ten days. The early-start group had more swelling, more pain, and the same range of motion at six weeks. The later-start group ended up **ahead** at the longer follow-up points. Starting later is not falling behind — it is getting ahead by not setting yourself back.

Your routine this week

- **Continue the hourly routine —** ankle pumps, knee bends, knee straightenings, 5 to 10 steps.
- **Continue 40 minutes of ice and elevation per hour.** Keep your EdemaWear on day and night.
- **Heel hangs three times a day, 5 minutes each.** This is when most patients first get the knee fully straight.
- **Step ceiling: 1,200 a day.** Still a ceiling. Two or three short outings is better than one long one.
- **Pain medicines tapering.** Many patients are off Norco and Ultram by the end of this week, with the anti-inflammatory and Tylenol carrying the load.

★ Your 2-week follow-up visit

You will see us around the 2-week mark for a wound check, staple or suture removal, and a range-of-motion check. The number we want by then is **110 degrees of bending.** Most patients are right there. If you are not, do not panic — we will work through it.

Weeks 3 and 4 — Build

This is where the real progress shows up. Swelling has dropped, range of motion is opening up, and the knee is ready to start doing actual work. Your therapist will start adding resistance and harder exercises now.

Where I want your knee by week 3

- **Flexion to 120 degrees.** That is enough to climb stairs comfortably, get in and out of a normal car, and sit at a dinner table without your leg sticking out.
- **Full extension.** Knee fully straight, matching what your therapist can move it to passively. Heel hangs are still doing this work.
- **Walking with the walker without thinking about it.** Smooth, steady, no limp.

Adding resistance — carefully

Now that the first two weeks are behind you, your therapist can add light resistance — **up to 3 pounds.** Not more. Heavier weights at this point stress the healing tissue and the gain is not worth the risk. Three pounds is enough to make the muscles work and rebuild without setting off swelling.

Your routine these weeks

- **Step ceiling week 3: 2,000 a day. Week 4: 2,750 a day.**
- **Range-of-motion exercises about 6 times a day,** 5 to 8 minutes each. Less hourly micromanagement than week 1; more focused sessions.
- **Ice and elevation 40 minutes at a time, 3 or more times a day.** Even though you are needing it less, do not stop using it.
- **Keep wearing your EdemaWear.** It is still doing real work through week 4 — possibly through week 6.
- **Most patients are off narcotics by now.** Anti-inflammatory and Tylenol on schedule; ice when it flares.

Is something not tracking with these weeks?

Recovery is not the same speed for every patient — age, baseline strength, and how much arthritis you started with all matter. But the shape of the curve should be the same: less swelling, more motion, less pain each week. If yours is plateauing or going backward, call us. The earlier we catch a problem, the smaller it stays.

Weeks 5 and 6 — Graduate from the walker

The 6-week mark is the line where most of the early restrictions come off. Get to it cleanly and the rest of your recovery is mostly just steady life with a new knee. Step ceilings keep climbing — **3,500 in week 5, 4,500 in week 6** — but pain and swelling should be your day-to-day guide, not the number.

The walker comes off when three things are true

- **You walk without a limp.** Smooth, even stride, both legs doing the same work.
- **You feel steady — really steady —** on uneven ground, on stairs, and when you turn.
- **Your therapist agrees.** Your PT can see your gait from the outside in a way you cannot. Their read carries weight here.

When all three are true, step down to a cane **in the opposite hand** from your operated knee — it gives you balance and unweights the surgical side. Use the cane on uneven ground and stairs even after you do not need it indoors. Plan on at least another week with the cane before going aid-free.

Driving

When you return to driving is a decision you make together with your therapist, once you feel comfortable, safe, and fully in control of the car. Two things have to be true first: you must be completely off narcotic pain medicine, and you need the strength and reaction time to move your foot quickly from gas to brake in an emergency stop. For most patients that point comes somewhere between two and six weeks. As a general rule, a left-side replacement lets you drive sooner than a right-side one, since your right leg does the braking. We'll also talk it through at your follow-up visit — but don't start driving on your own before you've had that conversation with your therapist or with us.

Return to work — a word of caution

Patients who try to return to work before 6 weeks often lose some of the range of motion they worked hard to gain. Even desk work is more demanding than it sounds — sitting all day adds swelling, and the commute eats into your ice-and-elevation time. If you can wait until 6 weeks, do. If your job is on your feet or involves stairs and lifting, plan for 8 to 12 weeks. Heavy labor is case by case — talk to me.

★ You are halfway there

At 6 weeks, the soft tissue around the knee is about **50% healed.** That is enough to lift the early restrictions, but it is not a finish line. The next stretch — weeks 6 to 12 — is where the joint really settles in. Stay with the program.

Beyond 6 weeks

At 6 weeks, the early restrictions come off and most patients are walking aid-free or with a cane only when needed. From here, recovery is steadier and less hour-by-hour. The longer arc still matters — most patients keep gaining for a full year, and the maximum benefit lands at around two years out.

Step ceilings keep climbing

Add about **1,000 steps a week** beyond your week 6 ceiling, letting pain and swelling guide you. If the knee swells more after a longer day, ease back the next day rather than push through.

The longer arc

- **12 weeks — about 90% healed.** Sleep usually back to normal. Most patients are aid-free, exercising regularly, and back to most of life.
- **6 months — back to most activities.** Many patients have already returned to work, hobbies, travel, and exercise. Scar still maturing.
- **1 year — full recovery for most.** Annual visit with x-ray. We confirm the implant is well-seated and you are doing well.
- **2 years — maximum benefit.** The last bits of stiffness and the deep soreness around the incision typically finish settling.

What opens up at 6 weeks

- **Twisting and pivoting are fine.** Tennis-style cutting is still a few weeks out, but everyday turning is back.
- **Kneeling and squatting are allowed,** but be gentle the first few times. Many patients have lasting tenderness on the front of the knee for months — that is normal, and a kneeling pad helps.
- **Most exercise is back on the table —** walking, swimming, stationary bike, elliptical, golf. Running and jumping sports are off the menu permanently for a knee replacement; they wear the joint out too fast.

Long-term — what you need to remember

Two protections matter for the life of your new joint. The **Brief Patient Guide** covers both in detail; the short version:

- **No dental work for 3 months.** Bacteria from the mouth can settle on a fresh implant.
- **Preventive antibiotics for life** before any dental work, including cleanings. Call us one week ahead and we send the prescription.

★ A new knee is not a young knee

The implant is excellent — **85 to 90 percent of them last 15 to 20 years** or longer. But it is a mechanical part, and high-impact activity wears it out faster. Walking, biking, swimming, golf, doubles tennis, and hiking are all great. Running, jumping, and singles tennis are not. Pick the activities that will let you keep this joint for the long run.

A few things patients always ask about

Here are the questions that come up in almost every follow-up visit. None of these are emergencies; they are the small worries that take up mental space when you are not sure what is normal.

"My knee is clicking and clunking. Is that normal?"

Yes — almost always. The plastic and metal surfaces of the implant make small sounds as they move against each other. Clicking, clunking, or even a faint metallic sound is common for the first few months and usually fades. It is not a sign that something is loose.

"The skin around my incision is numb."

Normal. The small nerves in the skin are cut during surgery. The area of numbness can be large at first and shrinks over time, but most patients have a patch of permanent numbness near the incision. It does not affect how the knee works.

"My knee feels warm to the touch."

A healing implant generates warmth. Up to 6 weeks of warmth around the joint is expected. The flag is warmth that is **sudden, spreading, or paired with fever, new redness, or new pain** — call us if you see that combination. Warmth on its own, fading week by week, is part of healing.

"When can I fly?"

Short flights under 2 hours: around 4 to 6 weeks for most patients. Longer flights and international travel: 6 to 12 weeks, with attention to DVT prevention — a compression sock on the flight, water, and getting up to walk at least once an hour.

"When can I have sex?"

Whenever you are comfortable, typically by week 2 or 3. Use positions that do not put weight on the operated knee or require deep flexion or twisting until 6 weeks. After 6 weeks, the restrictions come off.

"I feel down, and I am not sure why."

Common, especially around days 10 to 14. The adrenaline of getting through surgery has worn off, recovery is still grinding on, and you may be more isolated than usual. Sometimes called "the dip." It usually passes within a week. If it does not, or if it is severe, tell us — recovery is harder when mood is in the basement, and we can help.

"My scar looks angry. Is it infected?"

Some redness right at the incision line is normal for the first few weeks. The patterns that worry me are: redness **spreading outward** beyond the incision, drainage that soaks through the dressing, opening of the incision, or a fresh fever above 101.5°F. Any of those — call. Take a photo for us and message it through the portal.

How to reach my team

My team and I are here for you before, during, and after surgery. Please use these to reach us — and if something does not feel right, reach out.

Send a portal message first when you can. Portal messages route directly to the right team member, which is usually faster than a voicemail. For phone calls, expect a callback within **1–2 business days.** Please leave one message only — calling repeatedly slows our response down for everyone, including you.

PATIENT PORTAL	CALL	AFTER HOURS
sbortho.com	**574-247-5164**	**574-247-9441**
Best for non-urgent questions, refill requests, and sharing photos.	Best when you need to talk to someone. Callback within 1–2 business days.	The on-call provider can be reached through the same number after hours.

★ When to go to the ER (do not wait for a callback)

- **Chest pain or shortness of breath.**
- **A calf that is suddenly swollen, hot, or painful.**
- **A fever above 101.5°F, or shaking chills.**
- **Heavy bleeding from the incision, or a fall onto the surgical side.**

We'd rather hear from you twice than miss a real concern.