PHYSICAL THERAPY PRESCRIPTION

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PATIENT STICKER

PATELLAR ORIF PHYSICAL THERAPY PRESCRIPTION

DATE OF SURGERY: _____ DIAGNOSIS: S/P (Left / Right) Patellar ORIF

0-6 WEEKS

___ Weight Bearing: Crutches/TDWB x 6 weeks with brace locked at 0°

___ Range of Motion

Weeks 0-2: PROM/AAROM – 0° to ___° flexion per MD discretion

Weeks 2-6: PROM/AAROM – add 15° flexion per week with a goal of ___° at 6 weeks

___ Straight Leg Raises / Quad Isometrics

>6 WEEKS

___ Discontinue brace/PWB with crutches, progress to FWB as tolerated

___ Advance ROM beyond ___°

___ Quadriceps and Hamstring stretching

___ Quadriceps Strengthening ___ V.M.O. Strengthening

___ Hamstring Strengthening

___ Iliotibial Band Stretching / Strengthening

___ Adductor/Abductor Stretching / Strengthening

___ Achilles Tendon Stretching

___ Electrical Stimulation for Quadriceps

___ Ice / Massage / Anti-Inflammatory Modalities

Treatment: _____ times per week ___ Home Program

Duration: _____ weeks

Physician's Signature: _____
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