

UCLA OUTPATIENT REHABILITATION SERVICES	
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ARTHROSCOPIC MENISCAL REPAIR (ACL INTACT KNEE)
PHYSICAL THERAPY PRESCRIPTION

**Diagnosis: s/p (LEFT / RIGHT) Knee Arthroscopic Meniscal Repair
 (Medial / Lateral)
 Surgery Date: _____**

- WEEK 1-2:** FORMCHECKBOX Ambulate PWB in Bledsoe Brace locked @ 0° in Full Extension for first 4 weeks
 FORMCHECKBOX Crutches 1-2 weeks
 FORMCHECKBOX Limit Range of Motion in weeks 1-2 from 0° to 70°
 FORMCHECKBOX Range of Motion: Active / Active-Assisted / Passive
 FORMCHECKBOX Quadriceps and Hamstring stretching
 FORMCHECKBOX Quadriceps Strengthening FORMCHECKBOX V.M.O.
- Strengthening
- FORMCHECKBOX Full Arc FORMCHECKBOX 0° - 30° Arc
 FORMCHECKBOX Hamstring Strengthening
 FORMCHECKBOX Begin Straight Leg Raises (Knee at 0° in Full Extension)
 FORMCHECKBOX Quad Isometrics
 FORMCHECKBOX Achilles Tendon Stretching
 FORMCHECKBOX Electrical Stimulation for Quadriceps
- WEEK 3-4:** FORMCHECKBOX Range of Motion in weeks 3-4 increase 0° to 90°
 FORMCHECKBOX Unlock Brace @ 4 weeks and return to normal gait
 FORMCHECKBOX May Begin Exercise Bike, Closed Kinetic Chain Exercises
- WEEK 5-6:** FORMCHECKBOX Range of Motion in weeks 5-6 increase to Full ROM
 FORMCHECKBOX Discard Brace @ 6 weeks

RETURN TO SPORT PHASE: FORMCHECKBOX Return to Running @ 3-4 months
FORMCHECKBOX Return to Full Sports @ 4-5 months

Treatment: _____ **times per week** **Duration:** _____ **weeks**
____ **Home Program**

**Please send progress notes.

Physician's Signature: _____ **Date:**

Kristofer J. Jones, M.D., Attending Orthopaedic Surgeon

Place label here

NAME OF PATIENT: _____

MRN: _____

Kristofer J. Jones, M.D.

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