

UCLA OUTPATIENT REHABILITATION SERVICES	
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KNEE ARTHROSCOPIC PHYSICAL THERAPY PRESCRIPTION

Diagnosis: s/p (LEFT / RIGHT) Knee Arthroscopic Partial Meniscectomy (Medial / Lateral)

Cartilage Wear Present: (YES / NO) Location: _____

Date of Surgery: _____

Phase I (Weeks 1-3) Emphasis = Pain Reduction, Edema Control, Motion & Quad Strength

- FORMCHECKBOX Quadriceps sets – Emphasize closed-chain, isometric quad strengthening
- FORMCHECKBOX Modalities as needed to decrease pain and swelling
- FORMCHECKBOX Heel slides to increase flexion ROM, as needed
- FORMCHECKBOX Stationary bicycle: zero / low resistance, as tolerated (emphasis is motion)
- FORMCHECKBOX Hamstring & Gastroc/Soleus stretching & flexibility
- FORMCHECKBOX Static weight-lifts
- FORMCHECKBOX Hamstring curls with light weight / low resistance
- FORMCHECKBOX Toe raises, calf pumps
- FORMCHECKBOX Isometric hip adduction, Hip adduction & abduction, as tolerate
- FORMCHECKBOX If pain-free & edema well-controlled, may incorporate low-resistance elliptical at 3-4 weeks

Phase II (Weeks 4-6) Emphasis = Strengthening & Flexibility

- FORMCHECKBOX Continue ROM and strengthening exercises, as needed
- FORMCHECKBOX Add leg-press within pain-free arc (begin with very low-weight, progress slowly)
- FORMCHECKBOX Add step-downs/ups, lunges, and/or partial low-weight squats as tolerated
- FORMCHECKBOX Add eccentric quadriceps and hamstring exercises
- FORMCHECKBOX Advance stationary bicycle to progressively incorporate greater resistance to build strength & endurance
- FORMCHECKBOX Advance elliptical resistance & begin jogging on mini-trampoline, progressing to treadmill running as tolerated

Phase III (Weeks 6-10) Emphasis = Strength & Functional Progression

- FORMCHECKBOX Continuing strengthening exercises
- FORMCHECKBOX SportCord exercises: knee extension (only if pain-free & no patellofemoral history), leg press (sitting & supine)
- FORMCHECKBOX Progress to outdoor running (e.g. track) and agility drills
- FORMCHECKBOX Add plyometric exercises as needed
- FORMCHECKBOX Begin practicing skills specific to the activity (i.e. work, recreational activity, sport, etc.)

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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