| UCLA OUTPATIENT REHABILITATION SERVICES | |
|---|---|
| ❑ **WESTWOOD**<br>1000 Veteran Ave., A level<br>Phone: (310) 794-1323<br>Fax: (310) 794-1457 | ❑ **SANTA MONICA**<br>1260 15th St, Ste. 900<br>Phone: (310) 319-4646<br>Fax: (310) 319-2269 |
| FOR APPTS, CALL: (310) 794-1323 | |
| FAX: (310) 794-1457 | |
| | |

## ORIF OCD LESION PHASE I PHYSICAL THERAPY PRESCRIPTION

**Diagnosis: s/p ( LEFT / RIGHT ) ORIF OCD Lesion – Date of Surgery: _____**

**Associated Pathology / Procedure: _____**

**PHASE I – REPAIR (WEEKS 0-12)**

**Goals:**

Control post-operative pain / swelling
Range of Motion 0 → 130°, as tolerated, no limits
Prevent Quadriceps inhibition
Normalize proximal musculature muscle strength
Independence in home therapeutic exercise program

**Precautions:**

Avoid weight bearing with crutches for 12 weeks
Avoid neglect of range of motion exercises

**Treatment Strategies:**

FORMCHECKBOX Active – Assistive Range of Motion Exercises (Pain-free ROM)
FORMCHECKBOX Towel extensions
FORMCHECKBOX Patella mobilization all planes
FORMCHECKBOX Postoperative bracing for 12 weeks postoperatively then can D/C
FORMCHECKBOX Quadriceps re-education (Quad Sets with EMS or EMG)
FORMCHECKBOX Multiple Angle Quadriceps Isometrics (Bilaterally – Submaximal, Avoid lesion)
FORMCHECKBOX SLR's (all planes)
FORMCHECKBOX Hip progressive resisted exercises
FORMCHECKBOX Cryotherapy
FORMCHECKBOX Plantar Flexion Theraband
FORMCHECKBOX Lower Extremity Flexibility exercises
FORMCHECKBOX Upper extremity cardiovascular exercises as tolerated
FORMCHECKBOX Home therapeutic exercise program: evaluation based
FORMCHECKBOX Emphasize patient compliance to home therapeutic exercise program and weight bearing progression

**Criteria for Advancement:**

ROM 0° → 130°
Proximal Muscle strength 5/5
SLR (supine) without extension lag

**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.**
Sports Medicine, Shoulder Surgery and Cartilage Restoration
UCLA Department of Orthopaedic Surgery
David Geffen School of Medicine at UCLA
10833 Le Conte Avenue, 76-143 CHS
Los Angeles, CA 90095-6902
Phone: (310) 825-6095
Fax: (310) 825-1311
CA License: A126262

**Surgery Type:**

**Location:**
**MFC ☐ LFC ☐ Trochlea ☐ Patella**
**MTP ☐ LTP**

**Brace use: _____ weeks**

**NWB x _____ weeks**

**Notes:**