UCLA OUTPATIENT REHABILITATION SERVICES	
WESTWOOD 1000 Veteran Ave., A level Phone: (310) 794-1323 Fax: (310) 794-1457	**SANTA MONICA** 1260 15th St, Ste. 900 Phone: (310) 319-4646 Fax: (310) 319-2269
FOR APPTS, CALL: (310) 794-1323	
FAX: (310) 794-1457	
Place label here NAME OF PATIENT: _____ MRN: _____	

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OSTEOCHONDRAL AUTOGRAFT / MOSAICPLASTY PHYSICAL THERAPY PRESCRIPTION

Diagnosis: s/p (LEFT / RIGHT) Knee Osteochondral Autograft / Mosaicplasty
Surgery Date: _____

Modalities:

Strict NWB x 6 weeks, may progress to FWB by 8 weeks
Range of Motion: Active / Active-Assisted / Passive
Limit ROM to _____° for first 4 weeks, then may progress ROM
CPM 3-4 hrs per day for first 6 weeks
Straight Leg Raises / Quad Isometrics
Quadriceps and Hamstring stretching
Quadriceps Strengthening V.M.O. Strengthening
Full Arc 0° - 30° Arc
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 Duration: _____ weeks ___ Home Program
**Please send progress notes.

Physician's Signature: _____ Date: _____
Kristofer J. Jones, M.D., Attending Orthopaedic Surgeon