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	

DISTAL FEMUR OSTEOTOMY PHYSICAL THERAPY PRESCRIPTION

Diagnosis: s/p (LEFT / RIGHT) Distal Femur Osteotomy Date of Surgery: _____

POST-OPERATIVE PHASE I (WEEKS 0-2)

Weight Bearing:
Heel touch only
Brace:
On at all times during day and while sleeping
Off for hygiene

ROM:
0-90° at home

Exercises:
___ Calf pumps, quad sets
___ SLR in brace, modalities

POST-OPERATIVE PHASE II (WEEKS 2-6)

Weight Bearing:
Heel touch only
Brace:
Brace may be removed for sleeping after 4 weeks
Open 0-90° and worn daytime only until 6 weeks
ROM:
Maintain full extension and progress flexion to full
Exercises:
___ Progress non-weight bearing flexibility, modalities
___ Begin floor-based core and glutes exercises
___ Advance quad sets, patellar mobs, and SLR

POST-OPERATIVE PHASE III (WEEKS 6-8)

Weight Bearing:
Advance 25% weekly and progress to full with normalized gait pattern

Brace:
None
ROM:
Full
Exercises:
___ Advance closed chain quads, progress balance, core/pelvic and stability work
___ Begin stationary bike at 6 weeks
___ Advance SLR, floor-based exercise; hip/core

POST-OPERATIVE PHASE IV (WEEKS 8-16)

Weight Bearing:
Full
Brace:
None
ROM:
Full
Exercises:
___ Progress flexibility/strengthening, progression of functional balance, core, glutes program
___ Advance bike, add elliptical at 12 weeks as tolerated
___ Swimming okay at 12 weeks

POST-OPERATIVE PHASE V (WEEKS 16-24)

Weight Bearing:
Full

Brace:
None
ROM:
Full
Exercises:
___ Advance Phase IV activity
___ Progress to functional training, including impact activity after 20 weeks when cleared by MD

Treatment: _____ times per week ___ Home Program

Duration: _____ weeks
**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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