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	

PATELLAR TENDON REPAIR PHYSICAL THERAPY PRESCRIPTION

Diagnosis: s/p (LEFT / RIGHT) Patellar Tendon Repair – Surgery Date: ______________

0-4 WEEKS:

FORMCHECKBOX Weight Bearing: TDWB x 2 weeks then progress to FWB

FORMCHECKBOX Range of Motion: Active Flexion, Passive Extension ONLY for first 6 weeks

** NO ACTIVE EXTENSION **

FORMCHECKBOX Limit ROM to ________° for first 4 weeks, then may progress ROM

FORMCHECKBOX Straight Leg Raises / Quad Isometrics

>4 WEEKS:

FORMCHECKBOX Quadriceps and Hamstring stretching

FORMCHECKBOX Quadriceps Strengthening FORMCHECKBOX V.M.O. Strengthening

FORMCHECKBOX Full Arc FORMCHECKBOX 0° - 30° Arc

FORMCHECKBOX Hamstring Strengthening

FORMCHECKBOX Iliotibial Band Stretching / Strengthening

FORMCHECKBOX Adductor / Abductor Stretching / Strengthening

FORMCHECKBOX Achilles Tendon Stretching

FORMCHECKBOX Electrical Stimulation for Quadriceps

FORMCHECKBOX Ice / Massage / Anti-Inflammatory Modalities

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: ____________________________________

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