

UCLA OUTPATIENT REHABILITATION SERVICES	
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Kristofer J. Jones, M.D.

Sports Medicine, Shoulder Surgery and Cartilage Restoration
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Place label here

NAME OF PATIENT: _____

MRN: _____

ACL INSUFFICIENCY PRE-OPERATIVE PHYSICAL THERAPY PRESCRIPTION

Diagnosis: (LEFT / RIGHT) ACL Insufficiency / Tear

DATE OF INJURY: _____ **APPROXIMATE DATE OF SURGERY:** _____

- GOALS:**
- 1) RECOVERY / RECUPERATION FROM INITIAL INJURY
 - 2) RESTORE NORMAL RANGE OF MOTION
 - 3) MINIMIZE INFLAMMATION AND EFFUSION
 - 4) IMPROVE PREOPERATIVE STRENGTH

- ___ Restore ROM
- ___ Quadriceps Isometrics. Quadricep Isotonics 90° – 30° arc
- ___ PWB - FWB
- ___ Leg lifts with / without weights
- ___ Hamstring / Hip PRE's
- ___ Stationary biking
- ___ Closed Chain activities: BAPS, half squats, step-ups, leg press, Nordic track

___ Balancing for joint stability
___ Patellar mobilization

Treatment: _____ **times per week**

Duration: _____ **weeks**

**Please send progress notes.

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

Date: _____