ARTHROSCOPIC MENISCUS ROOT/RADIAL REPAIR PHYSICAL THERAPY PRESCRIPTION

Diagnosis: S/p (Left / Right) Knee Arthroscopic Meniscal Root/Radial Repair

Date of surgery: _____

PHASE I (0 to 2 WEEKS):

GOALS:
Pain control
Decrease swelling

EXERCISES/RESTRICTIONS:
Brace at all times, locked in extension while not performing exercises and sleeping
Weight bearing status: Non weight bearing with crutches
ROM: Limited from 0-90°. Active / Active-Assisted / Passive
Patella mobilizations
Quad strengthening: Straight leg raise, quad isometrics

PHASE II (2 to 6 WEEKS):

GOALS:
ROM to 90
Meniscus healing
Quadriceps control
Good patella mobility

EXERCISES/RESTRICTIONS:
Brace at all times, locked in extension while not performing exercises and sleeping
Weight bearing status: Non weight bearing with crutches
ROM: Limited from 0-90°. Active / Active-Assisted / Passive
Patella mobilizations
Quad strengthening: Straight leg raise, quad isometrics
Modalities OK PRN
Home exercise program

PHASE III (6 to 12 WEEKS):

GOALS:
ROM to normal
Normal patellar mobility
Restore normal gait
Ascent stairs with good control

Return to normal ADL

EXERCISES/RESTRICTIONS:
Unlock brace, then wean off crutches and out of brace with good gait and swelling well controlled
ROM: Full ROM. Active / Active-Assisted / Passive
Leg press—0-90 deg arc
Strengthening: No knee loading with knee flexion greater than 90° until 3 months
Step-up/Step-down / Lunges and squats
Proprioception/balance program
Hip/CORE program
Stairmaster/elliptical
Modalities OK
Home exercise program

PHASE IV (12 to 20 WEEKS):

GOALS:
Descend stairs with good control
Improve flexibility
Running at 4-5 months when cleared by MD

EXERCISES/RESTRICTIONS:
Progress squat program
Advance quad/hamstring program
Proprioception training
Agility exercises
Lower extremity stretching
Modalities
Home exercise program

Evaluate and treat per therapist plan.
Please follow the protocol as directed and call the office with questions or renewals.
**Please send progress notes.

NAME OF PATIENT: _____

Treatment: ____ times per week **Duration: ____ weeks** **___ Home Program**

Physician's Signature: _____ Date: _____

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