ACHILLES TENDON REPAIR PHYSICAL THERAPY PRESCRIPTION

Diagnosis: S/p (Left / Right) Achilles Tendon Repair

Date of surgery: _____

PHASE 1 (0 to 2 WEEKS):

GOALS:
Pain and edema control
Protect from accidental injury
Minimize gluteus, quadriceps and hamstring atrophy
Soft tissue and wound healing

EXERCISES/RESTRICTIONS:
Non-weight bearing in plantarflexion splint with crutches
Elevation
Strengthening: Quad sets, Hamstring stretching, Straight leg raise, Hip abduction exercises

PHASE 2 (2 to 6 WEEKS):

GOALS:
Pain and edema control
Wound healing, avoid over elongation of Achilles
Scar mobility
Restore ankle plantarflexion, inversion and eversion

EXERCISES/RESTRICTIONS:
Partial weight bearing with crutches, plantarflexion in boot
Can begin full weight-bearing as tolerated at week 4
Heel wedges, wean down after week 4, neutral by week 6
PROM/AAROM/AROM: ankle dorsiflexion to neutral, plantar flexion, inversion, eversion, ankle circles. No passive heel cord stretching
Upper body strengthening
Knee/hip exercises with no ankle involvement
Ok for exercises bike with boot in place

PHASE 3 (6 to 12 WEEKS):

GOALS:
Normalize gait
Protect repair, avoid over elongation

Restore full range of motion
Safely progress strengthening
Promote proper movement patterns

EXERCISES/RESTRICTIONS:
Full weight bearing as tolerated in boot without heel wedges. Wean out of boot at week 8
Begin active plantarflexion - begin with isometrics, progress to isotonics
Dorsiflexion isotonics
Achilles tendon stretch with towel. ROM exercises
Balance/proprioception

Phase 4 (3-6 months):

GOALS:
Safely progress strengthening
Promote proper movement patterns

EXERCISES/RESTRICTIONS:
Elliptical, stair climber
Standing gastroc stretch and soleus stretch as indicated
Calf raises eccentric, seated calf machine
Proximal strengthening / balance

Phase 5 (>6 months):

GOALS:
Continue strengthening and proprioceptive exercises
Safely initiate sport specific training program
Symmetrical performance with sport specific drills
Safely progress to full sport

EXERCISES/RESTRICTIONS:
Return to Running Program
Agility and Plyometric 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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