

PATELLA FRACTURE ORIF PHYSICAL THERAPY PRESCRIPTION

Diagnosis: Left / Right knee patella fracture

Surgery: ORIF patella fracture

Date of surgery: _____

PHASE I (0 to 2 WEEKS):

GOALS:

Pain control
Decrease swelling

EXERCISES/RESTRICTIONS:

Weight bearing as tolerated with brace locked in extension for sleeping and all activities
Ice / Massage / Anti-Inflammatory / Modalities
Range of Motion
 0-30 degrees when not weight bearing
NO ACTIVE EXTENSION, ONLY PASSIVE EXTENSION
Patellar mobility
Straight leg raise only with brace on
Quad isometrics
Calf pumps

PHASE II (2 to 8 WEEKS):

GOALS:

Bone healing
Decreased swelling, pain control
Slow progression of ROM

EXERCISES/RESTRICTIONS:

Weight bearing as tolerated only with brace on and locked in extension.
Wear brace while sleeping until week 6, then can remove brace for sleeping at 6 weeks post-op
Ice / Massage / Anti-Inflammatory / Modalities

<u>Weeks</u>	<u>Brace</u>	<u>ROM</u>
1-2	Locked in extension during day and night, set 0	0
3-4	Locked in extension during day and night, set 0-30	0-30, progress slowly
5-6	Locked in extension during day, off at night, set 0-45	0-45, progress slowly
7-8	Locked in extension during day, off at night, set 0-90	0-90, progress slowly

NO ACTIVE EXTENSION, ONLY PASSIVE EXTENSION

Patellar mobility
Straight leg raise only with brace on
Quad isometrics
Calf pumps

PHASE III (8 to 12 WEEKS):

GOALS:

Bone healing
Patellar mobilization
Gentle knee ROM and progressive strengthening

EXERCISES/RESTRICTIONS:

Weight bearing as tolerated, brace removed
Range of motion: full
Progress closed chain activities
Begin hamstring work, lunges/leg press 0-90°
Proprioception exercises
Balance/core/hip/glutes
Begin stationary bike when able

PHASE IV (12 to 20 WEEKS):

GOALS:

Return to regular activities

EXERCISES/RESTRICTIONS:

Progress Phase III exercises and functional activities
Single leg balance
Core
Glutes
Eccentric hamstrings
Elliptical, and bike, swimming okay at 12 weeks
Advance to sport-specific drills and running/jumping after 20 weeks once cleared by MD

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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