

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

Weeks

Brace

ROM

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: _____

Daniel J. Chernoff, M.D.

Orthopedic Surgery, Sports Medicine
Kansas City Orthopedic Alliance
3651 College Blvd. Leawood, KS 66211
Phone: (913) 319-7600
Fax: (913) 253-1704
KS License: 04-46252
MO License: 2019014833
NPI: 1326401456

