PATELLAR TENDON REPAIR PHYSICAL THERAPY PRESCRIPTION

Diagnosis: S/p Left / Right knee patellar tendon Repair

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 4, then can remove brace for sleeping at 4 weeks post-op
Ice / Massage / Anti-Inflammatory / Modalities

Weeks	Brace	ROM
1-2	Locked in extension during day and night, set 0-30	0-30
3-4	Locked in extension during day and night, set 0-45	0-45, progress slowly
5-6	Locked in extension during day, off at night, set 0-60	0-60, 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:
Tendon 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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