ILIOTIBIAL BAND FRICTION SYNDROME (NON-OP)
NON-OP PHYSICAL THERAPY PROTOCOL

Patient Name: _____ Date: _____

_____ Evaluate and Treat _____ Provide patient with home program

Frequency: _____ x/week x _____ weeks

Modalities:

_____ Phonophoresis with 0.05% Fluocinonide

_____ Iontophoresis with 4mg/ml Dexamethasone

_____ Ultrasound

_____ Electrical Stimulation

Exercises:

_____ Back Stabilization Program

_____ PatelloFemoral Exercise

_____ Hip Exercise Program

Special Instructions:

Foam Rolling; Stretching IT Band

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.
This patient _____ would _____ would not benefit from social services.

Physician Name: _____ Date: _____

The Christ Hospital™ Physicians
Joint & Spine