Patient Name: _____   Date of Surgery: _____

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: _____ x/week   x   _____ weeks

_____ **Phase I (0 – 2 weeks):**
- **Weightbearing:** Partial weight bearing with crutches.***
- **Brace:** Locked in full extension for sleeping and all activity.*
        Off for exercises and hygiene.
- **Rom:** 0-90° when non- weight bearing.
- **Exercises:** Heel slides, quad sets, patellar mobs, SLR, SAQ.**
        No weight bearing with flexion >90°

_____ **Phase II (2-8 weeks):**
- **Weightbearing: 2-4 weeks:** 50% WB with crutches.
                4-8 weeks: Progress to full WB.
- **Brace: 2-6 weeks:** Unlocked 0-90°.
        Off at night.
        Discontinue brace at 6 weeks.
- **Rom:** As tolerated.
- **Exercises:** Addition of heel raises, total gym (closed chain), terminal knee extensions.**
        Activities w/ brace until 6 weeks; then w/o brace as tolerated.
        No weight bearing with flexion >90°

_____ **Phase III (8-12 weeks):**
- **Weightbearing:** Full.
- **Brace:** None.
- **Rom:** Full.
- **Exercises:** Progress closed chain.
        Begin hamstring work, lunges/leg press 0-90°,
          proprioception exercises, balance/core/hip/glutes.
        Begin stationary bike.

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_____ **Phase IV (12-20 weeks):**

- **Weightbearing:** Full.
- **Brace:** None.
- **Rom:** Full.
- **Exercises:** Progress Phase III exercises and functional activities: single leg balance, core, glutes, eccentric hamstrings, elliptical, and bike.
  Swimming okay at 16 weeks.

_____ **Phase V (>20 weeks):**

- **Weightbearing:** Full.
- **Brace:** None.
- **Rom:** Full.
- **Exercises:** Advance to sport-specific drills and running/jumping once cleared by MD.

*Brace may be removed for sleeping after first post-operative visit (day 7-10)

**Avoid any tibial rotation for 8 weeks to protect meniscus

***Weight bearing status may vary depending on nature of meniscus repair. Please refer to specific PT Rx provided to patient for confirmation of WB status

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: _____

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