



# PATELLA OPEN REDUCTION INTERNAL FIXATION (ORIF) Physical Therapy Protocol

Patient Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

**Procedure:** Right / Left Patella ORIF

\_\_\_\_\_ Evaluate and Treat

\_\_\_\_\_ Provide patient with home program

**Frequency:** \_\_\_\_\_ x/week x \_\_\_\_\_ weeks

\_\_\_\_\_ **Phase I (0-6 weeks):** *Period of protection. A home-program alone may suffice for this period of time. Formal PT may be helpful after 6 weeks once ROM is initiated in the brace..*

- WBAT with crutches, brace locked in extension during all weight-bearing activity and during sleep.
- ROM:
  - Knee: patients to perform active prone knee flexion as tolerated 2-3 x per day within the confines of the brace wear. No active extension or forced passive flexion. All ROM should be non-weightbearing and with the brace on, following the progression below:
    - 0-4 weeks:** Brace locked in full extension (0 degrees).
    - 4-5 weeks:** Brace unlocked from 0-30 degrees.
    - 5-6 weeks:** Brace unlocked from 0-60 degrees.
    - 6-7 weeks:** Brace unlocked from 0-90 degrees.
  - Ankle/Hip: ROM exercises 2-3 x per day.
  - Strict elevation while seated.
  - No quadriceps strengthening until at least 6 weeks post-op.

\_\_\_\_\_ **Phase II (6-12 weeks):** *Begin regular, supervised strengthening and wean from the brace.*

- Wean from crutches, then D/C brace once ambulating with a normal gait and can perform SLR without an extension lag.
- ROM: After 7 weeks postop, brace fully unlocked; advance active and active-assisted ROM as tolerated; gentle passive stretching at end-range. Goal: 0-120 or greater by 12 weeks.
- Strengthening:
  - Begin isometric quad sets, SLRs.
  - Progress to closed chain strengthening (no open-chain) once out of the brace.

\_\_\_\_\_ **Phase III (3-6 months): *Begin more sport-focused conditioning.***

- Advance strengthening as tolerated, continue closed-chain exercises. Increase resistance on equipment.
- At 5 months, start jogging and progress to agility training and/or other sport-specific rehab as tolerated.
- Begin to wean patient from formal supervised therapy encouraging independence with home exercise program by 6 months.

\_\_\_\_\_ **Other:**

\_\_\_\_\_ Modalities

\_\_\_\_\_ Electrical Stimulation

\_\_\_\_\_ Ultrasound

\_\_\_\_\_ Heat before/after

\_\_\_\_\_ Ice before/after exercise

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: \_\_\_\_\_