MCL / LCL / PLC TEAR (NON-OP) – 2-WEEKS POST-INJURY
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:

_____ ACL Exercise Program *(with brace on, see restrictions)*

Weightbearing:

_____ Touchdown

Special Instructions:

Gradual increase in weight-bearing (always with brace on), 25% WB increase/week x 4 weeks

Gradually progress ROM to full (all stretching with brace on)

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