OSTEOCHONDRAL ALLOGRAFT TRANSPLANTATION (OAT) TO FEMORAL CONDYLE Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

__ **Evaluate and Treat** __ **Provide patient with home exercise program**

Frequency: _____ x/week x _____ weeks

_____ **Phase I (0-6 weeks):** ***Period of protection****

- **Weightbearing:** Heel touch.
- **Brace 0-2 week:** Locked in full extension at all times.
  Off for CPM and exercise only.
  Discontinue after 2 weeks.
- **ROM – 0-6 weeks:** Use CPM for 6 hours/day, beginning at 0- 40°; advance 5- 10° daily as tolerated.
- **Exercises 0-2 weeks:** Quad sets, SLR, calf pumps, passive leg hangs to 90° at home.
  2-6 weeks: PROM/AAROM to tolerance, patella and tibiofibular joint mobs, quad, hamstring, and glut sets, SLR, side-lying hip and core.

_____ **Phase II (6-8 weeks):**

- **Weightbearing:** Advance 25% weekly until full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Advance Phase I exercises .

_____ **Phase III (8-12 weeks):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Gait training, begin closed chain activities: wall sits, shuttle, mini-squats, toe raises
  Begin unilateral stance activities, balance training.

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_____ **Phase IV (12 weeks-6 months):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Advance Phase III exercises; maximize core/glutes, pelvic stability work, eccentric hamstrings
  May advance to elliptical, bike, pool as tolerated.

_____ **Phase V (6-12 months):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Advance functional activity.
  Return to sport-specific activity and impact when cleared by MD after 8 months.

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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