PHYSICAL THERAPY PRESCRIPTION

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DATE: ______________________

PATIENT NAME: ____

D.O.B: ______________________ **MRN:** ______________________

DIAGNOSIS: ACL TEAR
❒ Right ❒ Left ❒ Bilateral

DATE OF INJURY: _________________________________

APPROXIMATE DATE OF SURGERY:_________________

<u>GOALS:</u>
1) RECOVERY / RECUPERATION FROM INITIAL INJURY
2) RESTORE NORMAL RANGE OF MOTION
3) MINIMIZE INFLAMMATION AND EFFUSION
4) IMPROVE PREOPERATIVE STRENGTH

Restore ROM
Quadriceps Isometrics. Quadricep Isotonics 90 deg – 30 deg arc
PWB - FWB
Leg lifts with / without weights
Hamstring / Hip PRE’s
Stationary biking
Closed Chain activities: BAPS, half squats, step-ups, leg press, Nordic track
Balancing for joint stability
Patellar mobilization
___ Other: ____

Treatment: ❒ Eval and Treat or ❒ 1 ❒ 2 ❒ 3 times per week

Duration: ❒ 4 ❒ 6 weeks

❒ Home Program

**Please send progress notes.

Physician’s Signature: ____
NPI #: 1164790507