

PHYSICAL THERAPY PRESCRIPTION

Jeffrey Wong, MD

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: KNEE MENISCUS TEAR: MEDIAL LATERAL
 Right Left Bilateral

___ Ice / Massage / Anti-Inflammatory Modalities

___ Range of Motion Active Active-Assisted Passive

___ Quadriceps and Hamstring stretching and strengthening

___ Iliotibial Band Stretching / Strengthening

___ Adductor/Abductor Stretching / Strengthening

___ Straight Leg Raises / Quad Isometrics

___ Exercise Bike ___ Stairclimber ___ Cybex

___ Achilles Tendon Stretching

___ Medial Patella Glides

___ Electrical Stimulation for Quadriceps

___ Hydrotherapy

___ 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