PHYSICAL THERAPY PRESCRIPTION

Jeffrey Wong, MD
SCOS Orthopedic Specialists
18785 Brookhurst Street, Ste 100
Fountain Valley, CA 92708
(714) 500-5056 Phone
(949) 900-2116 Fax

DATE: ____________________

PATIENT NAME: ____

D.O.B: ____________________ **MRN: ____________________**

DIAGNOSIS: KNEE MENISCAL ROOT TEAR: ❐ MEDIAL ❐ LATERAL
❐ Right ❐ Left ❐ Bilateral
SURGERY: KNEE MENISCAL ROOT REPAIR
DATE OF SURGERY: __________

General guidelines

- NWB with crutches and brace locked in extension x 4 weeks; progress to full WB by 8 weeks and wean crutches and brace
- Avoid knee flexion > 90° for 6 weeks
- Do not load bent knee x 6 weeks

Rehab:

- Ice / Massage / Anti-Inflammatory Modalities
- Immediate ROM (active, active assist, passive)
- Quadriceps and Hamstring stretching / strengthening
- Straight Leg Raises / Quad Isometrics / electrical stimulation
- Hydrotherapy at 4 weeks
- Exercise Bike 0-90° x 6 weeks, then advance to full ROM and add elliptical at 6 weeks

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