PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: KNEE STIFFNESS / ARTHROFIBROSIS
❒ Right ❒ Left ❒ Bilateral
SURGERY: _____
DATE OF SURGERY: _____

___ Ice / Massage / Anti-Inflammatory Modalities

___ Range of Motion - Active / Active-Assisted / Passive

___ Quadriceps and Hamstring stretching

Begin prone hamstring stretching immediately, with goal of achieving symmetric hyperextension

___ Progress to Quadriceps and Hamstring Strengthening once full ROM restored

___ Patellar glides / mobilization: medial/lateral, superior/inferior

___ Electrical Stimulation for Quadriceps

___ Hydrotherapy

___ Exercise Bike ___ Stairclimber ___ Cybex

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