Diagnostic or Staging Knee Arthroscopy

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Patient Name	Date of Surgery

Procedure: ☐ Right ☐ Left Knee Arthroscopy
Associated Procedure: *(check if applicable)* ☐ Partial Meniscectomy/Debridement ☐ Fat Pad/Plica Debridement
☐ Lysis of Adhesions (LOA) with Manipulation Under Anesthesia (MUA)

☐ **Evaluate and Treat – no open chain or isokinetic exercises**
☐ **Provide patient with home exercise program**

☐ **Phase I (Weeks 1-2)***:** *Initial recovery.*

- Weight bearing as tolerated without assist by 48 hours post-op.
- ROM: Progress through passive, active and active-assisted ROM as tolerated
  - Goal: Full extension by 2 weeks, 130 degrees of flexion by 6 weeks
- Patellar mobilization daily
- Strengthening: quad sets, SLRs, heel slides, etc.. No restrictions to ankle/hip strengthening.

☐ **Phase II (Weeks 2-6)***:** *Advance ROM and strengthening.*

- ROM: Continue with daily ROM exercises
  - Goal: Increase ROM as tolerated; aggressive end-range stretching as tolerated
- Strengthening: Begin and advance closed chain strengthening to full motion arc.
  - Add pulley weights, theraband, and other modalities as per PT discretion.
  - Advance to wall sits, lunges, balance ball, leg curls, leg press, plyometrics as tolerated.
  - Continue stationary bike and biking outdoors for ROM, strengthening, and cardio. Progress to sport-specific activities as tolerated.
  - Monitor for anterior knee symptoms, modulating exercises as necessary.

****If a lysis of adhesions (LOA) and manipulation under anesthesia (MUA) was performed at the same time, patient needs to wear a knee immobilizer (or hinged knee brace, locked in extension) at all times except during PT and for hygiene. CPM is usually ordered for 2-4 hrs per day x 6wks.*

☐ **Other:**

☐ Modalities
☐ Heat before/after
☐ May participate in aquatherapy after week three, begin aqua-running week 6
☐ Electrical Stimulation
☐ Ultrasound
☐ Ice before/after exercise

Frequency:__________________x/week x __________________weeks

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 Signature	Date

Printed Name