TWIN CITIES ORTHOPEDICS

Femoral Condyle/Tibial Plateau Microfracture

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Patient Name	Date of Surgery

Procedure: ☐ Right ☐ Left Knee Femoral Condyle/Tibial Plateau Microfracture
Associated Procedure: *(check if applicable)* ☐ ACI biopsy ☐ Partial Meniscectomy/Debridement

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

☐ **Phase I (0-6 wks):** *Period of protection.*
- **Toe-Touch Weight bearing (20%) with crutches.** A brace is not required.
- **ROM:**
  - CPM: 6 hrs/day, 1 cycle/minute, starting with a ROM that is comfortable for the patient. Advance motion 10 degrees each day as tolerated. If CPM is not available at any point during this time, patients are to perform 1500 active-assisted cycles of the knee per day (seated at the edge of a table, with the knee over the edge).
  - Gentle passive, active-assisted and active non-weightbearing (heel slides) ROM as tolerated. Goal: full ROM by week 6.
- **Strengthening:** quad sets, co-contractions, isometric quad/hamstring strengthening, all non weight-bearing.

☐ **Phase II (6-12 wks):** *Transition phase.*
- **Gradual return to full weight bearing.** Continue crutch use, but increase weightbearing gradually (roughly 30% each week). Full weight-bearing by the end of this phase.
- **ROM:** D/C CPM and progress to full active and passive ROM.
- **Strengthening:** Continue prior exercises, advancing to closed-chain strengthening once full weight-bearing.

☐ **Phase III (3-6 months):** *Begin more sport-focused conditioning.*
- **ROM:** Continue active and active-assisted ROM.
- **Strengthening:** Progress closed-chain strengthening without limits. Begin treadmill walking at a slow pace and progress to balance/proprioception.
- Light plyometrics and jogging can be initiated once full quad/hams strength achieved, followed by sport-specific drills**.**
- High-impact activities (jumping, contact sports) are allowed after 4-5 months if full ROM and strength achieved, and no pain with sport-specific rehab.

☐ **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	