TWIN CITIES ORTHOPEDICS

Patellar Or Quad Tendon Repair

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Patient Name	Date

Procedure: ☐ Right ☐ Left Knee ☐ Patellar ☐ Quad Tendon Repair

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

☐ **Phase I (0-6 wks):** *Period of protection. A home-program alone may suffice for this period of time.*

- **WBAT with crutches, brace locked in extension *during all weight-bearing activity and during sleep.***
- **ROM:**
  - Knee: patients to perform active prone knee flexion as tolerated 2-3 x per day. No active extension or forced passive flexion. All ROM should be non-weightbearing and with the brace on, following the progression below:
    - 0-2 wks: Brace unlocked from 0-30 degrees.
    - 2-4 wks: Brace unlocked from 0-60 degrees.
    - 4-6 wks: Brace unlocked from 0-90 degrees.
  - Ankle/Hip: ROM exercises 2-3 x per day.
  - Strict elevation while seated.
  - No quadriceps strengthening until at least 6 wks post-op.

☐ **Phase II (6-12 wks):** *Begin regular, supervised strengthening and wean from the brace.*

- **Wean from crutches, then D/C brace once ambulating with a normal gait and can perform SLR without an extension lag.**
- **ROM:** brace fully unlocked; advance active and active-assisted ROM as tolerated; gentle passive stretching at end-range. Goal: 0-120 or greater by 12 weeks.
- **Strengthening:**
  - begin isometric quad sets, SLRs
  - progress to closed chain strengthening (no open-chain) once out of the brace.

☐ **Phase III (3-6 months):** *Begin more sport-focused conditioning.*

- Advance strengthening as tolerated, continue closed-chain exercises. Increase resistance on equipment.
- At 4.5 months, start jogging and progress to agility training and/or other sport-specific rehab as tolerated
- Begin to wean patient from formal supervised therapy encouraging independence with home exercise program by 6 months.

☐ **Other:**

☐ Modalities
☐ Heat before/after
☐ 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	