



Knee Arthroscopy, Partial Meniscectomy, Fat Pad/Plica Debridement

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Patient Name	Date of Surgery
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Procedure: Right Left Knee Arthroscopy Partial Meniscectomy/Debridement Fat Pad/Plica Debridement
Associated Procedure: (check if applicable) 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.
- Work diligently on edema/effusion measures (RICE)

***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:

- | | |
|---|--|
| <input type="checkbox"/> Modalities | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Heat before/after | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> May participate in aquatherapy after week three, begin aqua-running week 6 | <input type="checkbox"/> 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 _____
