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Physical Therapy Prescription
EXCISION OF OSTEOCHONDROMA

Patient Name: _____ **Today's Date:** _____ **Surgery Date:** _____

Dx: s/p (LEFT / RIGHT) Osteochondroma removal, femur

MODALITIES			
TIME PERIOD	WEIGHT BEARING	RANGE OF MOTION	EXERCISES
0-2 weeks	As tolerated. Crutches first few 1-2 weeks as needed.	No restrictions other than pain	Heel slides, quds sets, straight leg raises. Patellar mobilization, weight shifts, Gait training
2-4 weeks	Full weight bearing	Full ROM by week 4	OKC quad, hip and glute exercises, balance exercises
4-6 weeks	Full weight bearing	Full ROM	Closed chain exercises (i.e. Dead lifts, light weight mini-squats, step ups, etc.)

Physical therapy to evaluate and treat for post-op partial meniscectomy

Frequency & Duration: (circle one) 1-2 2-3 x/week for ____ weeks

**Please send progress notes.

Physician's Signature: _____ **M.D.**