UNIVERSITY OF UTAH HEALTH CARE

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Physical Therapy Prescription
Hip Arthroscopy – Labral Repair General Rx

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

Dx: s/p (LEFT / RIGHT) Labral repair with or without FAI component

MODALITIES				
TIME PERIOD	**WEIGHT BEARING**	**RANGE OF MOTION**	**BRACE**	**EXERCISES**
0-2 weeks	WBAT	CPM for 4 hours/day ideal. Bike for 20-30 min/day x 2. PROM as tolerated but NO ER > 20 degrees. Limit hip extension to neutral	None	Hip isometrics – NO FLEXION with resistance. Pelvic tilts, supine bridges, quadruped rocking and PROM for hip flexion, gait training, modalities
2-4 weeks	WBAT. Wean off crutches (2→1→0) as gait normalizes	Continue previous tx, progress ROM, bent knee fall outs, BAPS rotations in standing. Hip flexor and ITB – manual and self, soft tissue mobilization.	None	Glut/piriformis rolling, core strengthening (avoid hip flexor tendinitis), hip strengthening – CKC, balance training (flat ground only), bike, easy hikes, swimming
4-8 weeks	WBAT Limit 45 lb load for all strength exercises x 12 weeks	Progress previous tx, full ROM, standing BAPS, prone hip IR/ER, ER with FABER, hip flexor / glut / piriformis / IT stretching, mobilization	None	Progress strengthening,closed chain hip exercises, leg press bilateral, short arc CKC strength, Weight limit 45#
8-12 weeks	WBAT	Full ROM	None	Progress LE and full body strengthening, hip endurance activities, Hip hinge exercises. Cont. 45# max load
12-16 weeks	WBAT Jogging may begin at 12 weeks post op	Full ROM	None	May begin linear progression of squat and deadlift, plyometrics, running program, sport specific agility drills
3-6 months **Criteria for Discharge**	WBAT	Full ROM	None	Hip Outcome Score, pain free or manageable discomfort, NO OPEN CHAIN BIODEX TESTING, Single leg cross-over triple hop for distance within 85% uninvolved, Deadlift body weight pain-free (HEX BAR okay)

Physical therapy to evaluate and treat for post-op hip arthroscopy.

Frequency & Duration: Evaluate post-op day 10-14, 1-2x/week for 1st 6 weeks, 1-2x/week for 2nd 6 weeks, 1-2x/week for 3rd 6 weeks (if needed)

**Please send progress notes.

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