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Physical Therapy Prescription Hip Arthroscopy – Labral Repair General Rx

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

DOB: _____ **Sex:** _____

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 except for walking	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 standing. Hip flexor and ITB – manual and self, soft tissue mobilization. Limit hip extension to neutral except for gait	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	Con't with above motion	None	Progress strengthening, closed chain hip exercises, leg press bilateral, short arc CKC strength, Weight limit 45#
8-12 weeks	WBAT	Con't with above motion	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. May begin to stretch anterior hip at this time	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.**