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Physical Therapy Prescription
Osteochondral Allograft

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

DOB: **Sex:**

Dx: s/p (LEFT / RIGHT) KNEE Osteochondral Allograft (MFC, LFC)

Weeks 0-4

___ Strict TTWB x 4 weeks with brace locked at 0 degrees
___ Hinged brace in full extension
___ Quadriceps, Adductor and Abductor isometrics
___ SLR's into flexion, extension, abduction and adduction (AAROM→AROM)
___ Passive and AAROM (ROM limited to 0-90° knee flexion for 4 weeks)
___ Manual and self-mobilizations for Hamstrings, Gastrocnemius, Hip flexors and ITB
___ Gentle Patella, fibular head and scar mobilization
___ NMES for Quadriceps re-education daily (Quad set, SLR and SAQ)
___ Cryotherapy and cryokinetics for pain

Weeks 4-6

___ Continue hinged brace in full extension.
___ Increase WBAT, brace locked straight for first 6 weeks
___ Continue core strength and stability
___ No restrictions on ROM when non-weight bearing
___ Con't quad activation exercises
___ Progress ROM to full active and passive by 8 weeks

Weeks 6-12

___ Discontinue Hinged brace in full extension
___ Full weight bearing as tolerated
___ Begin gait training and standing proprioceptive training on unstable surface
___ Progress to closed kinetic chain strengthening for lower extremity
___ Progress to CKC strengthening – Push and hinge variations
___ Begin rotation and anti-rotation trunk and spinal extensor exercises

Weeks 12-24

___ Continue to progress proprioceptive training
___ Begin linear progression of squat and hip hinge resistance training
Squat variations: Back, Front, Overhead, Sumo, Split Squat, Single leg, Bulgarian Split Squat, High box Step Up, Leg Press, Hex Bar Squat, Total Gym
Hip hinge variations: Conventional deadlift, RDL, Good Morning, GHD/Reverse Hyper, Straight Leg Dead, Hip Thrusters, SL dumbbell, kettle bell swing, Nordic HS, Bridging
___ Begin light jogging at 12 weeks if eccentric step down is symmetric
___ Begin agility drills in single plane, frontal and sagittal
___ Pivoting to begin at 4.5 months
___ Assess posture and functional movement patterns. Corrective exercise as needed.

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

**Please send progress notes.

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