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Physical Therapy Prescription – Knee Arthroscopy

Name: _____ **Date:** _____

Procedure: R / L arthroscopic **Date of Surgery:** _____

Frequency: 2-3 times per week for _____ weeks

PHASE I (Weeks 0 – 2): decrease edema, activate quadriceps

- **Weightbearing:** As tolerated; okay to use crutches for 2-3 days if needed
- **Brace**: None
- **Range of Motion:** AAROM → AROM as tolerated
- **Therapeutic Exercises:** Patellar mobs, quad/hamstring sets, heel slides, step-ups, straight-leg raises, stationary bike as tolerated; core exercises
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase II (Weeks 2 – 4)

- **Weightbearing:** As tolerated
- **Brace**: None
- **Range of Motion:** Full
- **Therapeutic Exercises:** Progress Phase I exercises; lunges, wall-sits; add cycling and elliptical
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase III (Weeks 4 – 6)

- **Weightbearing:** As tolerated
- **Brace**: None
- **Range of Motion:** Full
- **Therapeutic Exercises:** Progress Phase II exercises; add plyometrics and sport-specific exercises; add running; return to athletic activity as tolerated at week 6
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature: _____ **Date:** _____