

Name: _____ Diagnosis/ICD-9: _____

Surgical Procedure/DOS: _____

Precautions/Remarks: _____

Physical Therapy Evaluate and Treat

Shoulder Rehabilitation

Arthroscopic Protocol

SAD

Labral Repair

RTC Repair

Isometrics

Scapular Stability

RTC Strengthening

TSA Protocol

Knee Rehabilitation

Arthroscopic Protocol

ACL Protocol

HS Autograft

BPTB Autograft

Allograft

Meniscus Repair

Microfracture

Gait Training

NWB

PWB _____ %

WBAT

Plyometrics Program

TKA Protocol

Hip Rehabilitation

Arthroscopic Protocol

Labral Debridement

Labral Repair

Osteoplasty

Gait Training

NWB

PWB _____ %

WBAT

THA Protocol

Ankle Rehabilitation

Per Protocol

PROM

AAROM

AROM

Isometrics

Gait Training

NWB

PWB _____ %

WBAT

Stability Program

Proprioception

Spine Rehabilitation

Stability Program

General

Therapeutic Exercise

Balance/Coordination

Home Exercise Program

Video Movement Analysis

Modalities as needed

Please include:

Ultrasound

Electrical Stimulation

Cryotherapy

TENS

Biofeedback

Physician Name: _____ Phone#: _____

Physician Signature: _____ Date: _____