CAPSULAR RELEASE OF THE KNEE

PHYSICAL THERAPY PROTOCOL

Bryan M. Saltzman, M.D.
OrthoCarolina
Assistant Professor of Orthopaedic Surgery, Atrium Health
Sports Medicine & Shoulder/Elbow
1915 Randolph Rd, Charlotte, NC 28207
704-323-3000
www.BryanSaltzmanMD.com

Patient Name: ______________________________ Date of Surgery: ____________

___ Evaluate and Treat **___ Provide patient with home program**

Frequency: ___________x/week x _________weeks

	WEIGHT BEARING	BRACE	ROM	EXERCISES
PHASE I 0-2 weeks 4-5 days/wk	As tolerated	None	As tolerated	Heel slides, quad/hamstring sets, Patellar mobilization; SLR, planks, bridges, abs, step-ups and stationary bike as tolerated. Supine and prone PROM/ capsular stretching with and without Tib-Fem distraction
PHASE II 2-4 weeks 3 days/wk	Full	None	Full	Progress Phase I exercises Advance rectus femoris/ Anterior hip capsule stretching

				Cycling, elliptical, running as tolerated
PHASE III 4-12 weeks 2-3 days/wk	Full	None	Full	

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient __ would __would not benefit from social services.

_______________________________ Date:__________________________

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