Murphy Wainer Orthopedic Specialists
A Division of Southeastern Orthopaedic Specialists, P.A.

Dax Varkey MD, MPH
Caroline McBane PA-C
1130 N. Church Street, Suite 100
336-375-2300 (tel)
336-375-2314 (fax)

Patient: ________________________________ Date of Surgery: __________

<u>Procedure</u>: Right/Left Femoral Osteochondral Autograft/Allograft

<u>Associated Procedure</u> (*circled if applicable*): Meniscectomy/Meniscal Repair

Phase I (0-6 wks): ***Period of protection***

Weight bearing: Touchdown weight bearing
Brace: Locked in extension at all times for 1 weeks except for except for CPM use and therapy exercises. Unlock brace to 90° at 1 weeks.
ROM: Progress through passive, active and active assisted ROM as tolerated, no more than 90° for first 6 weeks. Ok for home knee hangs to comfort
CPM (MD discretion): Remove brace, start 0-20° post-op day 1 at low speed to comfort and increase 10° per day. DO NOT SLEEP WITH LEG ON CPM. Replace brace afterwards.
Exercises: Weeks 0-2 – Quad sets, SLR, calf pumps, passive leg hangs to 90°. Weeks 2-6 – AAROM and PROM of knee, patella. Quad, glut, hamstring sets. SLR. Core exercises.

Note: if a meniscal repair was done simultaneously, please amend the above with the following restrictions:
-WBAT with brace limited to 0-90 degrees x 4 weeks
-Limit ROM 0-90 degrees x 4 weeks
-No tibial rotation x 4 weeks

Phase II (6-12 wks): ***Advance weight bearing and work on strength***

Weight bearing: Advance to full over a 3 week span
Brace: None
ROM: No limitation
CPM: Discontinue
Exercises: Continue expanding on Phase 1 activities. Work on gait patterns, progress to wall sits, closed chain exercises. At 10 weeks work towards balance and unilateral stance activities.

Phase III (12 wks-6 mo): ***Strengthening and gait***

Weight bearing: Full
Brace: None
ROM: No limitation
Exercises: Core and glute strengthening, low impact activities like bike, swimming and elliptical, progression to jogging at 5 months if muscle control appropriate

Phase IV (6 mo-12 mo): ***Advanced activities***

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Weight bearing: Full
Brace: None
ROM: No limitation
Exercises: Return to sport specific activities and impact at about 8-12 months depending on MD clearance.

Frequency: ___________x/week x _________weeks

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.

___________________________ **Date:__________________________**

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