

Patient: _____ Date of Surgery: _____

Procedure: Right/Left Autograft/Allograft PCL reconstruction

Associated Procedure (circled if applicable): Meniscectomy/Meniscal Repair

Phase I (0-4 wks): *Period of protection*

Weight bearing: WBAT

Brace: Locked in extension for ambulation for first 4 weeks. OK to remove for sleep at week 1. PT can unlock for motion only during exercises.

ROM: Progressive prone passive ROM only. It's important to avoid posterior sag during all motion.

Ice: Not directly on skin. Recommend as much as possible. 5x/day, 20 min/session for first 2 weeks. Then after activity at minimum.

Exercises: Patellar mobilization, SLR with brace on, ankle pumps, calf press with exercise bands.

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 (4-12 wks): *Advance strengthening*

Weight bearing: Full

Brace: Unlock brace fully. Discontinue brace at 6 weeks.

ROM: No limitation, increase as tolerated.

Ice: Not directly on skin. Recommend as much as possible, at minimum after therapy.

Exercises: Leg press 0-60°, ambulation in pool, wall slides and mini-squats.
Stairmaster, elliptical trainer, seated calf raises.

Phase III (12 wks-9 mo): *Strengthening and progression to jogging*

Weight bearing: Full

Brace: None

ROM: No limitation. It's not unusual to lack 10-15° for 5 months postop.

Exercises: Advanced strengthening as tolerated, increase resistance on equipment. May begin elliptical. Wean from formalized therapy and encourage independence with home exercise program. Strict avoidance of open chain exercises.

Jogging: Begin straight ahead jogging program if core and hip strength appropriate at 4.5 mo to 5 mo post-op, no sooner unless instructed by MD.

Phase IV (9 mo-12 mo): *Advanced activities*

Weight bearing: Full

Brace: None

ROM: No limitation

Exercises: **AVOID HIGH RISK ACTIVITIES UNTIL MD CLEARANCE.** Return to sport specific activities and impact at about 8-12 months depending on functional testing and 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: _____

Dax Varkey MD, MPH