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## Physical Therapy Prescription deNOVO Juvenile Cartilage Allograft

**Patient Name:**

**Today's Date:**

**Surgery Date:**

**Dx: s/p ( LEFT / RIGHT) KNEE deNOVO Cartilage Allograft ( PF, MFC, LFC )**

**Modalities:**

Toe-Touch (TTWB) x 4 weeks, may progress to FWB by 6 weeks

Open hinges on brace at 4 weeks

Range of Motion     Active / Active-Assisted / Passive

Limit ROM to \_\_\_\_\_° deg for first 4 weeks, then may progress ROM

CPM 3-4 hrs per day for first 6 weeks

Straight Leg Raises / Quad Isometrics

Quadriceps and Hamstring stretching

Quadriceps Strengthening      V.M.O. Strengthening

Full Arc      0-30° Arc

Hamstring Strengthening

Iliotibial Band Stretching / Strengthening

Adductor/Abductor Stretching / Strengthening

Achilles Tendon Stretching

Electrical Stimulation for Quadriceps

Ice / Massage / Anti-Inflammatory Modalities

**Frequency & Duration:** (circle one) 1-2    2-3 x/week for \_\_\_\_\_ weeks    Home Program

\*\*Please send progress notes.

**Physician's Signature:** \_\_\_\_\_ **M.D.**