Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

ILIOTIBIAL BAND FRICTION SYNDROME (NON-OP)

NON-OP PHYSICAL THERAPY PROTOCOL

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Patient Name: _____ **Date**: _____

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

Frequency: ___2-3_____**x/week x** ____6_____**weeks**

Modalities:

_X_ Phonophoresis with 0.05% Fluocinonide

_X_ Iontophoresis with 4mg/ml Dexamethasone

_X_ Ultrasound

_X_ Dry Needling*

_X_ Electrical Stimulation

Exercises:

_X_ Back Stabilization Program

_X_ PatelloFemoral Exercise

_X_ Hip Exercise Program

Special Instructions:

Foam Rolling; Stretching IT Band

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

_____ Date:_____

Bryan M. Saltzman, MD