



ACL TEAR 'PREHAB'

PRE-SURGICAL PHYSICAL THERAPY PROTOCOL

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Patient Name: _____ **Date:** _____

Evaluate and Treat

Provide patient with home program

Frequency: 2-3 x/week x 4 weeks

Modalities:

Phonophoresis with 0.05% Fluocinonide

Iontophoresis with 4mg/ml Dexamethasone

Ultrasound

Electrical Stimulation

Exercises:



Back Stabilization Program

PatelloFemoral Exercise

Hip Exercise Program

Special Instructions:

ACL Prehab – work on stretching, ROM, Quad/HS activation and strengthening in preparation for ACL reconstruction surgery

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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