CAPSULAR RELEASE OF THE KNEE
Physical Therapy Protocol

Patient Name: ____ Date of Surgery: ____________________

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: ______ x/week x ______ weeks

_____ Phase I (0-2 weeks 4-5 days/week):

- **Weight Bearing:** As tolerated.
- **Brace:** None.
- **ROM:** As tolerated.
- **Exercises:** Heel slides, quad/hamstring sets.
  Patellar mobilization; SLR, planks, bridges, abs, step-ups and stationary bike as tolerated.
  Supine and prone PROM/ capsular stretching with and without Tib-Fem distraction.

_____ Phase II (2-4 weeks 3 days/week):

- **Weight Bearing:** Full.
- **Brace:** None.
- **ROM:** Full.
- **Exercises:** Progress Phase I exercises.
  Advance rectus femoris/ Anterior hip capsule stretching.
  Cycling, elliptical, running as tolerated.

_____ Phase III (4-12 weeks 2-3 days/week):

- **Weight Bearing:** Full.
- **Brace:** None.
- **ROM:** Full.

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.

Physician Name: ____ Date: ____________________

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