Suzanne L. Miller, MD
Julie Winn, PA-C

****PLEASE TAKE THIS ORDER WITH YOU TO YOUR FIRST PT EVALUATION****

Knee Arthroscopy Physical Therapy Prescription

Patient Name: ____

Surgery: _________ Knee Arthroscopy Date of Surgery: ____________

- ☐ Partial medial meniscectomy
- ☐ Partial lateral meniscectomy
- ☐ Removal of loose body
- ☐ Other: ________________________
- ☐ Medial compartment chondroplasty
- ☐ Lateral compartment chondroplasty
- ☐ Patellofemoral chondroplasty

Prescription: Progressive range of motion, modalities for edema and pain reduction, patella mobilization, progressive resistive exercise

Frequency: 2-3x a week for 8-12 weeks

Grade and location of chondral changes (Kellgren – Lawrence classification):

Patellofemoral compartment:

Patella:	I	II	III	IV
Trochlea:	I	II	III	IV
Medial Compartment:	I	II	III	IV
Lateral Compartment:	I	II	III	IV

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Signature/Date

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