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## Physical Therapy Prescription MCL Tear Rehab

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Dx: (LEFT/RIGHT) MCL TEAR**

\_\_\_\_\_ **NON-OP**

\_\_\_\_\_ **PRE-OP**

**Modalities:**

- \_\_\_ Ice / Massage / Anti-Inflammatory Modalities
- \_\_\_ Range of Motion     Active / Active-Assisted / Passive
- \_\_\_ Quadriceps and Hamstring stretching
- \_\_\_ Quadriceps Strengthening     \_\_\_ V.M.O. Strengthening
  - \_\_\_ Full Arc     \_\_\_ 0-30° Arc
- \_\_\_ Hamstring Strengthening
- \_\_\_ Avoidance of Valgus loading at all times
- \_\_\_ Straight Leg Raises / Quad Isometrics
- \_\_\_ Exercise Bike
- \_\_\_ Achilles Tendon Stretching
- \_\_\_ Medial Patella Glides
- \_\_\_ Electrical Stimulation for Quadriceps
- \_\_\_ Hydrotherapy

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

\*\*All motion protocols to be done in hinged brace; Avoid all valgus stress

\*\*Please send progress notes.

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