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**PATELLA/ QUAD TENDON REPAIR**  
**POSTOPERATIVE PROTOCOL**  
Referral for Rehabilitation Services

Patient Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
\_\_\_\_\_/ Week \_\_\_\_\_ Weeks

Weight bearing as tolerated with knee brace locked in extension for 6-8 weeks.

**PHASE 1 - Weeks 1-2**

Goals: Control pain and inflammation  
Maintain patellar mobility and hamstring strength  
Active knee flexion to 30 degrees, passive terminal knee extension

Exercises: 1. Isometric hamstring exercise  
2. Patellar mobs  
3. AROM, AAROM, and PROM

**PHASE 2 – Weeks 2-4**

Goals: Control pain and inflammation  
Maintain patellar mobility  
Range of motion 0-60  
Begin quadriceps retraining

Exercises: 1. Continue with phase 1 exercises  
2. Start quadriceps sets (NO straight leg raises)

**PHASE 3 – Weeks 4-6**

Goals: Possibly discontinue crutch use depending on patient's gait  
Continue use of immobilizer in extension during ambulation  
Range of motion 0-90

Exercises: 1. Continue phase 1 & 2  
2. Gait training if good quadricep control is achieved

**PHASE 4 – Weeks 6-12**

Goals: Progress to full AROM  
Continue hinged knee brace locked in extension until good quad control and normal gait is obtained  
Continue quadricep retraining

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- Exercises:
1. Gait training
  2. Isometric hamstring exercises
  3. Patella mobs
  4. AROM
  5. Quadricep strengthening: straight leg raises without resistance
  6. Stationary cycling at 8 weeks

**PHASE 5 – Weeks 12-16**

- Goals:
- Complete weight bearing
  - Begin neuromuscular retraining
  - Maintain/progress quadricep strength

- Exercises:
1. No immobilization
  2. Quadricep strengthening
  3. Proprioception and balance activities (incl. single leg support)

**PHASE 6 – Weeks 16-24**

- Goals:
- Begin running
  - Sport specific/Job training

- Exercises:
1. Progress program as listed for phase 5 with sport/job training

**PHASE 7 – >6 months**

May begin jumping and contact sports when strength is 85-90% of contralateral extremity

*I hereby certify these services as medically necessary for the patient's plan of care.*

\_\_\_\_\_  
Physician's Signature

Date\_\_\_\_\_