PATIENT NAME: _____

DATE: _____

ANKLE ARTHROSCOPY PROTOCOL

PHYSICAL THERAPY:

WEEK 1-4: SWELLING CONTROL AND PAIN CONTROL MODALITIES.
WBAT ALLOWED.
JOINT MOBILIZATION AND AROM AS TOLERATED.
PROGRESSIVE RESISTANCE EXERCISES AND INTRINSIC STRENGTHENING. CLOSED CHAIN EXERCISES AS TOLERATED.

WEEK 4-8: ADVANCE RESISTIVE EXERCISES. ADVANCED BALANCING TRAINING.
BEGIN PROPRIOCEPTIVE TRAINING EXERCISES AND PNF.
IONTOPHORESIS AS NEEDED.

WEEK 9-12: BEGIN RUNNING, SPORT SPECIFIC TRAINING AND WORK HARDENING AS NEEDED FOR RETURN TO FULL ACTIVITY.

FREQUENCY: _____ DURATION: _____

PHYSICIAN SIGNATURE: _____