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SPECIALIZING IN SHOULDER & KNEE SURGERY

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PHYSICAL THERAPY REFERRAL: ANKLE SPRAIN PROTOCOL

Diagnosis: _____

Visits: 10-12 Frequency: 1-2x / week Duration: 6 weeks

Evaluate & Treat

Follow Protocol

Establish Home Program

Modalities :

Exercise:

- | | |
|----------------------------|--------------------------|
| ● Whirlpool | ● Passive ROM |
| ● Contrast Bath | ● Active/Assistive ROM |
| ● Ice | ● Strengthening (PRE) |
| ● Hot/cold packs | ● Stretching/flexibility |
| ● Ultrasound/phonophoresis | ● Gait training |
| ● Electrical Stimulation | ● Functional progression |
| ● Biofeedback | ● General conditioning |
| ● Massage | ● Home exercise program |
| ● As indicated | ● As indicated |

Other/Comments:

Peroneal, Posterior tibialis, and Gastroc/soleus strengthening,

Core strengthening, Quad strengthening, Gluteal strengthening,

AAROM exercises, Proprioceptive Work, Balance Control,

Edema Control, Gait Normalization, Functional Progression.

Please send progress notes.

Signature: _____

