STEPHAN J. SWEET, M.D., M.P.H. A Professional Corporation Sports Medicine, Arthroscopy, & General Orthopedic Surgery

PHYSICAL THERAPY PRESCRIPTION

DIAGNOSIS (LEFT / RIGHT) OPEN ANTERIOR SHOULDER STABILIZATION AND/OR LATARJET CORACOID TRANSFER DATE OF SURGERY:

SHOULDER SURGERY PHYSICAL THERAPY PRESCRIPTION

RECOVERY /RECUPERATION PHASE (0-6 WEEKS POST-OP):

- __Immobilization for 4-6 weeks EXCEPT for exercises
- ___ PROM with pulleys *I* cane for Flexion @ 3 weeks
- __NO ACTIVE IR
- ___ PROTECT ANTERIOR CAPSULE FROM STRETCH Limit ER to neutral
- ___ POSTERIOR CAPSULE STRETCHING WHEN WARM
- ____ Hand, Wrist, Grip strengthening
- ___ Modalities, Cryocuff / Ice, prn

6 – 12 WEEKS POST-OP:

- ___Active/Active-Assisted Elevation, ER / IR. Use good arm to help operated arm
- ____At <u>6-8 weeks</u>: ER to 30° degrees with arm at side
- ____At 8-10 weeks: ER to 45° degrees with arm at side
- ____At 10-12 weeks: ER to 45° degrees with arm in 45° degrees ABD
- ___Begin Deltoid and Rotator cuff Isometrics @ 6 weeks. Progress to Isotonics
- ____Theraband for ER exercises
- ____ Continue with Scapula strengthening, increase arc motion
- ____ Continue with wrist / forearm strengthening
- ___Continue with POSTERIOR CAPSULE STRETCHING WHEN WARM
- ___ Keep all strengthening exercises below horizontal
- NO PASSIVE STRETCHING. PROTECT ANTERIOR CAPSULE
- __Modalities as needed
- ____Discontinue sling @ 4-6 weeks

LIMITED RETURN TO SPORT PHASE (12 - 20 WEEKS POST-OP):

- __Active ROM activities to restore full ROM. Restore Scapulo-Humeral rhythm
- __Continue Posterior Capsule stretching Continue muscle endurance activities
- __Progress from modified neutral into ABD for cuff PRE's
- ___Aggressive Scapula strengthening and eccentric strengthening program
- ___Begin Plyometric training for overhead athletes
- ___ Begin lsokinetics for Rotator cuff
- ____ At <u>16 weeks:</u> begin sport specific activities: gentle throwing, golf swing, forehand / backhand
- __ Limited return to sports @ 18-20 weeks.

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ADDITIONAL INFORMATION / INSTRUCTIONS:

Treatment:_____times per week Duration:_____weeks

Physician's Signature:_____ Date:_____