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

PHYSICAL THERAPY PRESCRIPTION

DIAGNOSIS: (LEFT / RIGHT) ______________________________

DATE OF SURGERY:______________________

SHOULDER FRACTURE PHYSICAL THERAPY PRESCRI PTION

___Range of Motion Active / Active-Assisted / Passive
LIMITS:_________________________

___Rotator Cuff and Deltoid Isometrics

___ Rotator Cuff and Deltoid Cuff and Scapular Stabilization program exercises - DO NOT BEGIN UNTIL
ROM 75% NORMAL (8-12 WEEKS POST-OP)
Begin below Horizontal
Begin with Isometrics for Rotator Cuff
Progress to Theraband, then to lsotonics

___Progress to Deltoid, Lats, Triceps and Biceps. Progress·Scapular Stabilizers to lsotonics below Horizontal

___ Return to Sport Phase:
Emphasize Eccentric Rotator Cuff and Scapular Stabilization exercises
Sport-specific Strengthening exercises
Sport-specific Strengthening with Theraband
Plyometric program for Overhead Athletes

___Modalities PRN Ultrasound / Phonophoresis / E-stim / Moist Heat *I* Ice

Treatment:__________times per week ____Home Program

Duration:__________weeks Re-evaluate at 12 weeks

Physician's Signature:____________________________ Date:______________________

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