

PHYSICAL THERAPY PRESCRIPTION

JOEL WEBER, MD

ORTHOPAEDIC SURGERY AND SPORTS MEDICINE
EVERGREEN HEALTH
360.794.3300 APPT
360.794.6610 FAX



PATIENT STICKER

Diagnosis: (LEFT / RIGHT) _____

DATE: _____

DATE OF SURGERY: _____

SHOULDER FRACTURE PHYSICAL THERAPY PRESCRIPTION

___ 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 POSTOP)
Begin below Horizontal
Begin with Isometrics for Rotator Cuff
Progress to Theraband, then to Isotonics

___ Progress to Deltoid, Lats, Triceps and Biceps. Progress Scapular Stabilizers to
Isotonics 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 / Ice

Treatment: _____ times per week _____ Home Program

Duration: _____ weeks Re-evaluate at 12 weeks

Physician's Signature: _____

Joel Weber, MD, Orthopaedic Surgeon