PHYSICAL THERAPY PRESCRIPTION

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PATIENT STICKER

DIAGNOSIS: (LEFT / RIGHT)_____ DATE_____

ELBOW ARTHROSCOPY PHYSICAL THERAPY PRESCRIPTION

___ Range of motion (Active, Active Assisted, Passive), LIMITS: Yes/No
LIMITS: Flex_____ Ex_____Pro_____ Supination_____

___ Brace: Yes/No Settings/Timeline_____

___ Passive stretching Wrist Extensors and Flexors
Begin with Elbow flexed
Progress to stretching with Elbow in extension

___ Strengthening: Begin if range of motion is near full: Biceps, Triceps, Wrist Flexors, Wrist Extensors, Resisted pronation and supination. Can begin with Isometric exercises, then progress to concentric and eccentric exercise as tolerated.

___ Ice before and after rehab exercises

___ Modalities (stim. Ionto, US)

Treatment: _____ times per week Duration: _____ weeks ___ Home Program

** Please send progress notes.

Physician's Signature:_____
Frank A. Petrigliano, MD, Attending Orthopaedic Surgeon, UCLA