PHYSICAL THERAPY PRESCRIPTION

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UCLA Health System

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:_____
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