PHYSICAL THERAPY PRESCRIPTION

FRANK A. PETRIGLIANO, MD
ORTHOPAEDIC SURGERY AND SPORTS MEDICINE
UCLA DEPARTMENT OF ORTHOPAEDIC SURGERY

310.319.1234 APPT

310.825.2126 OFFICE
310.825.1311 FAX
CA License: A90515

PATIENT STICKER

Diagnosis: (LEFT / RIGHT)

DATE:_____

SHOULDER PHYSICAL THERAPY PRESCRIPTION

___ Range of Motion Active / Active-Assisted / Passive

___ Posterior Capsule Stretching after warm-up

___ Emphasize Internal Rotation

___ Rotator Cuff and Deltoid Isometrics

___ Rotator Cuff and Deltoid Cuff and Scapular Stabilization program exercises
- 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**

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