

PHYSICAL THERAPY PRESCRIPTION

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Keck Medicine
of USC

PATIENT STICKER

DATE OF SURGERY: _____

DIAGNOSIS: (LEFT/RIGHT) _____

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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