PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ **MRN: _____**

DIAGNOSIS: CLAVICLE FRACTURE
❒ Right ❒ Left ❒ Bilateral

Shoulder ROM and WB restrictions – avoid overhead activity x 6 wks

Pendulums, supine PROM at 2 wks weight limit. NWB, may weightbear for ADLs.

AAROM at 4 wks – 5 lb limit

AROM at 6 wks – 10 lb limit

Deltoid, rotator cuff, scapular stabilizers strengthening program – begin at 10-12 weeks – full WB

Sling – ❒ Wean from sling ❒ Sling at all times

___ Other: _____

Treatment: ❒ Eval and Treat or ❒ 1 ❒ 2 ❒ 3 times per week

Duration: ❒ 4 ❒ 6 weeks

❒ Home Program

**Please send progress notes.

Physician's Signature**:** _____

NPI #: 1164790507