PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: SHOULDER _____
❒ Right ❒ Left ❒ Bilateral

___ Range of Motion ❒ Active ❒ Active-Assisted ❒ Passive

___ Posterior Capsule Stretching after warm-up

___ Emphasize Internal Rotation

___ Rotator Cuff, Deltoid, and Scapular Stabilization program exercises
Begin below horizontal
Begin with isometrics for rotator cuff, progress to Theraband and then to Isotonics
Progress to deltoid, lats, triceps, 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

___ 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