

PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: PROXIMAL HUMERUS FRACTURE

Right Left Bilateral

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

Pendulums, PROM at 2 wks – NWB, may weightbear for ADLs

AAROM at 4 wks – 5 lb limit

AROM at 6 wks – 10 lb limit

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

Sling – circle one:

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