

# PHYSICAL THERAPY PRESCRIPTION

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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

D.O.B: \_\_\_\_\_ MRN: \_\_\_\_\_

**DIAGNOSIS:** SHOULDER ROTATOR CUFF TEAR

Right  Left  Bilateral

Range of Motion  Active  Active-Assisted  Passive

Begin below horizontal

Progress to 90 and overhead as tolerated in pain free arc

Rotator Cuff and Scapular stabilization program exercises

Begin with Isometrics for Rotator Cuff, progress to theraband and then to isotonic

Limit ER to neutral if (+) Biceps Tendonitis

Progress to Deltoid, Lats, Triceps, and Bicep

“Lawn Chair” Deltoid strengthening program for massive tears

Progress scapular stabilizers to isotonic below horizontal

Return to Sport Phase:

Emphasize eccentric Rotator Cuff and scapula stabilization exercises

Sport specific strengthening with Theraband

Plyometric program for overhead athletes

Modalities prn

\_\_\_ 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