PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS: SHOULDER SLAP TEAR
❒ Right ❒ Left ❒ Bilateral

Phase 1 – Regain full motion
Pendulums to warm up
Begin with PROM, advance to AAROM and then AROM when full passive motion achieved
Avoid position of abduction and external rotation
Avoid loading biceps

Phase 2 – Strengthening
Full ROM permitted including position of abduction and external rotation
Begin rotator cuff and scapular strengthening exercises
Start with bands, progress to light weights
No long lever-arm, abducted position or impingement position exercises

Phase 3 – Return to play
Continue ROM
Sport-specific rehab including throwing program as needed

___ 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