PHYSICAL THERAPY PRESCRIPTION

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DATE: _____

PATIENT NAME: _____

D.O.B: _____ MRN: _____

DIAGNOSIS**:** FROZEN SHOULDER
❒ Right ❒ Left ❒ Bilateral
SURGERY: _____
DATE OF SURGERY: _____

UNDERLYING PHILOSOPHY: PRESERVE RANGE OF MOTION AND BEGIN STRENGTHENING

___ Range of Motion (Increase IR, ER, FE, ABD) - Active / Active-Assisted / Passive

___ Rotator Cuff and Scapular stabilization program exercises

___ Begin with Isometrics for Rotator Cuff - Progress to Theraband, then to Isotonics

___ Progress to Deltoid, Lats, Triceps, and Biceps

___ Modalities prn

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