

# PHYSICAL THERAPY PRESCRIPTION

**Jeffrey Wong, MD**

SCOS Orthopedic Specialists  
18785 Brookhurst Street, Ste 100  
Fountain Valley, CA 92708  
(714) 500-5056 Phone  
(949) 900-2116 Fax

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

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

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

DIAGNOSIS: SHOULDER POSTERIOR LABRAL TEAR

Right  Left  Bilateral

SURGERY: \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_

## PHASE I – IMMOBILIZATION PHASE (0-3 WEEKS)

No shoulder motion.

Wear sling at all times when not bathing

Cryotherapy

## PHASE 2 – PROTECTED RANGE OF MOTION (4-6 WEEKS)

Wean from sling

Begin pendulums and supine PROM – FF, ER

Avoid stretching posterior capsule

## PHASE 3 – STRETCHING / STRENGTHENING PHASE (7-12 WEEKS)

Continue to gradually advance PROM, progress to AAROM and AROM

Focus on FF / ER

Gentle progression of IR

Begin strengthening program – first with bands, advance to light weights

Rotator cuff

Scapular stabilizers

Rows / shrugs

Biceps / triceps

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## PHASE 4 – RETURN TO PLAY (12 WEEKS AND BEYOND)

Continue stretching and strengthening

May begin weight lifting with low weight / high reps

At 16 weeks, may begin progressive throwing and overhead activity

Sport-specific return to play


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