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: PROXIMAL HUMERUS FRACTURE
❒ Right ❒ Left ❒ Bilateral
SURGERY: PROXIMAL HUMERUS ORIF
DATE OF SURGERY: _____

Weightbearing status: ❒ NWB ❒ PWB ❒ WBAT

Sling for ___ weeks, then wean

Shoulder ROM

Immediate pendulums and PROM

AAROM 2 wks

AROM 4 wks

Deltoid and rotator cuff strengthening program at 6 weeks

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