UCLA OUTPATIENT REHABILITATION SERVICES	
❑ **WESTWOOD** 1000 Veteran Ave., A level Phone: (310) 794-1323 Fax: (310) 794-1457	❑ **SANTA MONICA** 1260 15th St, Ste. 900 Phone: (310) 319-4646 Fax: (310) 319-2269
FOR APPTS, CALL: (310) 794-1323	
FAX: (310) 794-1457	

SHOULDER PHYSICAL THERAPY PRESCRIPTION

Diagnosis: _____

___ Range of Motion: Active / Active-Assisted / Passive

___ Posterior Capsule Stretching after warm-up

___ Emphasize Internal Rotation

___ Rotator Cuff and Deltoid Isometrics

___ Rotator Cuff and Deltoid Cuff and Scapular Stabilization program exercises
- Begin below Horizontal
- Begin with Isometrics for Rotator Cuff
- Progress to Theraband, then to Isotonics

___ Limit ER to neutral if Biceps Tendonitis

___ Progress to Deltoid, Lats, Triceps, and Biceps. Progress Scapular Stabilizers to Isotonics below Horizontal

___ Return to Sport Phase:
- Emphasize Eccentric Rotator Cuff and Scapular Stabilization exercises
- Sport-specific Strengthening exercises
- Sport-specific Strengthening with Theraband
- Plyometric program for Overhead Athletes

___ Modalities PRN Ultrasound / Phonophoresis / E-stim / Moist Heat / Ice

Treatment: _____ times per week	**___ Home Program**
Duration: _____ weeks	**___ Re-evaluate at 12 weeks**

**Please send progress notes.

Physician's Signature: _____ Date: _____
Kristofer J. Jones, M.D., Attending Orthopaedic Surgeon

Place label here

NAME OF PATIENT: _____

MRN: _____

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