Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

CAPSULAR RELEASE OF THE SHOULDER

PHYSICAL THERAPY PROTOCOL

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Patient Name: _____ **Date of Surgery**: _____

___ **Evaluate and Treat** ___ **Provide patient with home program**

Frequency: _____**x/week x** _____**weeks**

	RANGE OF MOTION	SLING	EXERCISES
PHASE I 0-4 weeks	Passive to active range as tolerated	**0-2 weeks**: Worn for comfort only **2-4 weeks**: Discontinue	**0-2 weeks**: Initiate outpatient PT according to Rx Aggressive PROM and capsular stretching*; closed chain scapula

			2-4 weeks: Continue capsular stretching: PROM, joint mobilization to max tolerance** Deltoid, cuff isometrics, begin scapular protraction/retraction
PHASE II 4-8 weeks	Increase as tolerated to full	None	Advance isometrics, rotator cuff and deltoid* Advance to therabands, dumbbells as tolerated** Continue capsular stretching and PROM
PHASE III 8-16 weeks	Progress to full motion without discomfort	None	Advance strengthening as tolerated begin eccentrically resisted motions and closed chain activities Advance to sport and fully activity as tolerated after 12 weeks

*If a distal clavicle excision is performed, horizontal adduction is restricted for 8 weeks post-op
**If a biceps tenodesis is performed, avoid active flexion of biceps and eccentric loads on biceps for 6 weeks post-op

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient __ would __would not benefit from social services.

_____ Date:_____

Bryan M. Saltzman, MD