

Posterior Shoulder Stabilization Protocol

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Patient Name	Date of Surgery
Procedure: ☐ Right ☐ Left Shoulder Shoulder Poste	ior Stabilization
☐ Evaluate and Treat	☐ Provide patient with home program
Frequency: x/week x	weeks
 Phase I (0-6 wks): Period of protection: In general, s PT). Motion and strengthening exercises are performable. Weeks 0-3: No formal PT. Shoulder immobilizer should be worn a Home exercises only (pendulums, elb Weeks 1-4: Begin formal PT (2-3 x/wk). Sling at all times (except for hygiene a ROM: Restrict motion to 90 deg FF / 20 Progress PROM g AAROM g A Heat before, ice after. 	ing should be worn at all times during this phase (except for hygiene and remed within strict motion limits. It all times (except for hygiene and pendulums). Ind PT). Ind PT). Ind PT). Ind PT). Ind PTO: Ind PT
Strengthening:	ER with arm at side / 60 deg ABD/IR behind back to waist. Ingthening (isometrics/light bands) within above motion limits. Do not begin
 Phase III (8-12 wks): Advance ROM and more ROM: Advance active and passive ROM to full w stretching after 10 wks if not at full motion. Goal: full ROM by 3 months. 	h gentle passive stretching at end ranges. Progress to aggressive passive etrics g bands g light weights (1-5lbs) w/8-12 reps x 2-3 sets for cuff, deltoid,
 Phase IV (3-12 months): Progress to sport/oc ROM: Aggressive passive stretching at end Strengthening/Activities: Continue bands/light weights as above Begin eccentrically resisted motions, plyor specific/job-specific exercises by 4 me Throwing: At 4.5 months, may begin light-tossing At 6 months throw from the pitcher's m Work: Overhead work without lifting is usuall Resume heavy labor once full-strengt 	cupation-specific rehab. ranges if full motion not yet achieved. 9, 3x/wk. etrics (weighted ball toss), proprioception (body blade) and progress to sport- nths. if full-strength and motion. und and/or return to collision sports (hockey, football, etc.). 2 possible at 4.5-6 months achieved (usually by 6-9 months) his patient and physical therapy is medically necessary.
Physician Signature	Date
Printed Name	