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Patient: ______________________________ Date of Surgery: ____________

Procedure: Right/Left Rotator Cuff Repair

Associated procedures:
Biceps Tenodesis: avoid resisted elbow flexion x 6 weeks
Distal Clavicle Resection: Avoid cross-body adduction x 6 weeks

Week 1: No formal PT. Sling at all times except for hygiene and pendulums if instructed. Home exercises of elbow and wrist ROM, grip strengthening and small pendulums.

Phase I (1-6 wks): *Begin formal PT (2-3x per week)*

- **Weight bearing:** NWB, ok for typing if in sling
- **Brace:** Sling at all times except hygiene. Pillow is optional for sling.
- **Ice:** Not directly on skin, recommend as much as possible. 5x/day, 20 min/session for first 2 weeks. Then after activity at minimum.
- **ROM:** PROM only – goal of forward flexion 140°, ER at side 40°, abduction 60° deg max.
- **Exercises:** None except grip strengthening.

Phase II (6-12 wks): *Discontinue immobilization*

- **Weight bearing:** < 2-5 lbs operative arm
- **Brace:** Discontinue sling after 6 weeks.
- **ROM:** Light passive stretching at end ranges. Begin AAROM (canes, pulleys, etc.) and progress supine to vertical. Gradually progress with AROM. Goal full motion by 12 weeks.
- **Exercises:** Begin periscapular, pec/lat/trapezius isometrics with arm below shoulder level. Deltoid and cuff isometrics with arm at side at 8 weeks. Begin light strengthening at 10-12 weeks at therapist discretion.

Phase III (12 wks-18 wks): *Progress with strength*

- **Weight bearing:** Advance to tolerance.
- **ROM:** No restriction
- **Exercises:** Advance as tolerated to bands and to light weights (1-5 lbs) with 8-12 reps x 2-3 sets for cuff, deltoid, scapular stabilizers. No more than 3x / week to avoid cuff tendinitis. Begin to eccentrically resisted motions.

Phase IV (18 wks to 9 mo): *Advanced activities*

- **Weight bearing:** Full
- **Sports:** At 5 mo ok to progress to light throwing. Golf may begin at 4 months.
- **Work:** Overhead heavy lifting can begin to tolerance at ~4 months. Heavy labor may take 4-6 months.
- **Exercises:** Start light gym weight training activities.

Frequency: ___________x/week x _________weeks

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.

____________________________ **Date:_________________________**

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