Murphy Wainer Orthopedic Specialists
A Division of Southeastern Orthopaedic Specialists, P.A.

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Patient: _________________________________ Date of Surgery: __________

Procedure: Right/Left Distal Biceps Tendon Repair

Week 1: No formal PT. Splint and sling for 1 week to be removed either in PT or with MD guidance.

Phase I (1-6 wks): Begin formal PT

Weight bearing: <2 lb weight limit, ok for ADL use below this limit.
Brace: Hinged elbow brace unlocked to 30° or limit of comfort in extension.
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: Extension - AROM and gentle PROM to a tension free endpoint. Increase about 10° per visit or to position of maximal comfort. Flexion – PROM only. PROM supination/pronation at 90°of flexion. Continue shoulder and wrist ROM.
Exercises: Cuff/Periscapular/forearm isometrics in brace within above limits.

Phase II (6-10 wks): Advanced motion and early strengthening

Weight bearing: <5 lb weight limit, avoid resisted elbow flexion.
Brace: Discontinue
ROM: Advance active and passive elbow extension to full (if not already achieved). Gentle passive stretching at end-ranges as tolerated. Begin gentle active elbow flexion (gravity only). Continue forearm supination/pronation, shoulder and wrist ROM. Goal: full, tension-free elbow and forearm motion by 9 weeks.
Exercises: Avoid resisted elbow flexion until 10 weeks. Progress cuff/periscapular and forearm isometrics. Modalities at PT discretion.

Phase III (10 wks to 6 mo): Progress to sport/occupation specific activities

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Weight bearing: Full, recommend avoidance of heavy impact activities till after 3.5 months if possible.
Brace: None
ROM: Unrestricted active and passive stretching to end ranges of motion.
Exercises: Continue bands progressing to light weights (1-5 lbs). Begin resisted. Elbow flexion and transition to closed chain upper extremity exercises. Progress to sport/occupation specific tasks.

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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