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US Specialists outheastern Orthopaedic Specialists, P.A.	336-375-2314 (fax)
Patient: Date of Surgery:	
Procedure: Right/Left SLAP Repair	
<b>First week:</b> Sling at all times except for hygiene and pendulums if instruction exercises of elbow and wrist ROM, grip strengthening and pendulums.	cted. Home
Phase I (0-4 wks): Begin formal PT (2-3x per week) Weight bearing: NWB, ok for typing if in sling Brace: Sling at all times. Pillow is optional for sling. Ice: Not directly on skin, recommend as much as possible. 5x/da for first 2 weeks. Then after activity at minimum. ROM: Restrict motion to 90° FF, 20 deg ER at side, IR to stomac ER behind head. No cross body adduction combined with FF. APROM→AAROM→AROM as tolerated within limits. Exercises: Cuff/periscapular/deltoid isometrics in sling within aboresisted FF or elbow flexion (biceps) for 6 weeks postop to protect	h. No IR up back or dvance
Phase II (4-12 wks): Discontinue immobilization Weight bearing: < 5 lbs operative arm Brace: Discontinue sling after 4 weeks. ROM: Advance active and passive ROM to full with gentle passive s ranges. Progress to aggressive passive stretching after 10 wks if not Exercises: Advance as tolerated from isometrics → bands → light w/8-12 reps x 2-3 sets for cuff, deltoid, scapular stabilizers (Only do cuff tendonitis)	at full motion. weights (1-5lbs)
Phase III (12 wks- 16 wks): Progress with strength Weight bearing: Advance to tolerance. ROM: No restriction, aggressive end range stretching if full motion Exercises: Continue bands/light weights as above, 3x/wk. Begin motions, plyometrics (weighted ball toss), proprioception (body blasport-specific/job-specific exercises by 4 months.	eccentrically resisted
Phase IV (16 wks to 6 mo): Advanced activities, sport specific rehable Weight bearing: Full Overhead Athletes: Light tossing at 4 months, 5 months may state mound if mechanics appropriate. Overhead light serves in tennis months. Full release at 4.5-5 mo. Work: Overhead heavy lifting can begin to tolerance at ~3 month take 4-6 months.	art pitching from and volleyball at 4
Frequency:x/week xweeks	
By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.	

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Date:\_\_\_\_\_