

Physical Therapy Prescription – Reverse Shoulder Replacement

Name: _____ Date: _____

Diagnosis: R / L Reverse Shoulder Replacement Date of Surgery: _____

Frequency: 2-3 times per week for _____ weeks, **beginning 6 weeks after surgery**

WEEKS 0 – 6: Period of protection → no therapy for the first 6 weeks

- **Sling with pillow:** Must wear at all times except for hygiene
- **Range of Motion:** No shoulder ROM allowed; elbow/wrist motion ONLY
- **Exercises:** Pendulums, grip strengthening

THERAPY Phase I (Weeks 6 – 12 after surgery):

- **Sling:** Discontinue at 6 weeks
- **Range of Motion:** PROM → AAROM → AROM as tolerated
 - **Caution with IR/backward extension**
- **Exercises:** begin light resisted ER, FF, ABD isometrics and bands (concentric motions only)
 - No scapular retractions with bands
 - **NO IR/backward extension exercises until 3 months postop**
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

THERAPY Phase II (Weeks 12 – 24 after surgery):

- **Range of Motion:** increase as tolerated with passive stretching at end ranges
- **Exercises:** continue Phase I and advance as tolerated for cuff, deltoid, and scapular stabilizers
 - Emphasize *low-weight, high rep* exercises
 - Begin resisted IR / backward extension with isometrics → light bands → weights
 - Begin eccentric motions, plyometrics, and closed chain exercises
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature: _____

Date: _____