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Physical Therapy Prescription – Total Shoulder Replacement

Name: _____ **Date:** _____

Diagnosis: R / L Total Shoulder Replacement **Date of Surgery:** _____

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

WEEKS 0 – 2: Period of protection → no therapy for the first 2 weeks

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

THERAPY Phase I (Weeks 2 – 6 after surgery):

- **Sling with abduction pillow:** Continue for a total of 6 weeks
- **Range of Motion:** PROM → AAROM → AROM as tolerated (except IR, backward extension)
  - Weeks 2-3 goals: FF to 90° and ER to 20° with arm at side, ABD max of 75° without rotation
  - Weeks 3-4 goals: FF to 120° and ER to 40° with arm at side, ABD max of 75° without rotation
  - **NO IR/backward extension ROM until 6 weeks postop to protect subscapularis repair**
- **Exercises:** Pendulums, grip strengthening
  - **NO IR/backward extension**
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

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

- **Sling:** Discontinue (unless in crowd or in slippery environment)
- **Range of Motion:** increase as tolerated; begin ROM for IR and backward extension as tolerated
- **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 III (Weeks 12 – 24 after surgery):

- **Range of Motion:** increase as tolerated with passive stretching at end ranges
- **Exercises:** continue Phase II 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:** _____