LOS ANGELES
ORTHOPEDIC SURGERY SPECIALISTS
AND ADVANCED ORTHOPEDICS

Physical/Occupational Therapy Prescription

Name:
Date of Birth:
Diagnosis: Frozen Shoulder **Code:** M75.0
Procedure: None

Surgery Date:

Instructions:

Range of motion:

- Please focus on increasing range of motion, with a focus on forward elevation, adducted external rotation, and adducted internal rotation.
- When working on flexion please block scapulothoracic and emphasize glenohumeral motion. No range of motion limitations.
- Mild discomfort while pressing into end-ranges is ok, but frank pain is not.
- Begin gently and progress as tolerated.

Strengthening:

- Ok incorporate active range of motion and strengthening per therapist's preference, with no specific limitations. However, focus upon motion and not upon strengthening.

Please provide with a home exercise program including table slides, wall climbs, cane exercises, and sleeper stretches, to be performed 3-4 times per day.

Modalities: Heat, massage, and pain medications before exercises and ice after. Remaining modalities per therapist's preference.

Frequency: 2-3 times/week

Duration: 6 weeks

Signature:

Date:

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