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Physical Therapy Prescription – Arthroscopic Capsular Release

Name: _____ **Date:** _____

Diagnosis: R / L Arthroscopic Capsular Release **Date of Surgery:** _____

Frequency: 3-5 times per week for _____ weeks

Phase I (Weeks 0 – 6 after surgery):

- **Sling:** Only for comfort, discontinue as soon as able
- **Ice:** Use ice machine/system at minimum 3-4 times/day for the first week
- **Range of Motion:**
  - Pulleys or continuous passive motion (CPM) machine 3-5 times/day
  - Elbow, forearm, and hand ROM unrestricted
  - Aggressive PROM and capsular mobility in all planes
  - Supervised PROM and capsular stretching at least 3 times/week
  - Initiate AROM when tolerated (no restrictions)

- **Exercises:** begin scapular stabilizers (protraction, retraction)
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase II (Weeks 6+):

- **Range of Motion:** full AROM
- **Exercises:** continue Phase I; begin gentle rotator cuff strengthening; but avoid strengthening in positions of impingement
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature:_____ Date:_____