

Dr. Stephen R. Shively DO

Department of Orthopedic Surgery – Sports Medicine
Hancock Regional Hospital
www.SteveShivelyDO.com
(317) 477-6683



Physical Therapy Prescription – Arthroscopic Rotator Cuff Repair

Name: _____ **Date:** _____

Diagnosis: R / L arthroscopic rotator cuff repair **Date of Surgery:** _____

Frequency: 2-3 times per week for _____ weeks

Phase I – Weeks 0-6

- **Sling with abduction pillow:** Must wear at all times except for hygiene.
- **Range of Motion:** PROM only, including FF, ER, and ABD (within a comfortable range); No AROM/AAROM
- **Exercises:** Grip strengthening, begin scapular exercises (while in sling) including elevation with shrugs depression, retraction, and protraction; NO shoulder strengthening or motion exercises permitted
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase II - Weeks 6 – 12 after surgery

- **Sling with abduction pillow:** Discontinue at 6 weeks
- **Range of Motion:** Progress PROM and begin AAROM > AROM
- **Therapeutic Exercises:** Progress Phase I exercises; Begin isometric exercises (use pillow or folded towel without moving the shoulder); no resistance exercises until 12 weeks after surgery
 - **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase III - Weeks 12 – 16+ after surgery

- **Range of Motion:** Progress to full, painless, AROM
- **Therapeutic Exercises:** Progress Phase II exercises, begin resistance exercises with elastic band or hand weights, including resisted scapular strengthening, rotator cuff strengthening, and deltoid strengthening
- Resistance exercises should be done 3 days/week, with rest between sessions
- **Do not do full or empty-can exercises > these place too much stress on the rotator cuff**
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature: _____ Date: _____