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**Physical Therapy Prescription – Superior Capsular Reconstruction**

**Name:** __________________________________________ **Date:** _________________________________

**Diagnosis:** R / L superior capsular reconstruction **Date of Surgery:** _______________________

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

**THERAPY Phase I - Weeks 6 – 12 after surgery**:

- **Sling with abduction pillow:** Discontinue at Week 6
- **Range of Motion:** PROM only, including FF, ER, and ABD (within a comfortable range); No AROM/AAROM
- **Exercises:** continue pendulums; begin scapular exercises including elevation with shrugs, depression,

retraction, and protraction; no resistance exercises before 3 months

- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

**THERAPY Phase II (Weeks 12 – 14 after surgery)**:

• **Range of Motion:** Progress PROM and begin AAROM à progress slowly
o Week 12-13: perform while supine
o Week 13-14: perform while back is propped up 45°; then advance to upright position o Use unaffected arm, stick, or cane to move postoperative arm into FF, ER, and ABD

- **Therapeutic Exercises**: Progress Phase I exercises; no shoulder strengthening yet
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

**THERAPY Phase III (Weeks 14 – 18 after surgery)**:

- **Range of Motion:** Begin to AROM in all planes à progress slowly
- **Therapeutic Exercises**: Begin isometric exercises (use pillow or folded towel without moving the shoulder)
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

**THERAPY Phase IV (Weeks 18 – 22 after surgery)**:

- **Range of Motion:** Progress to full, painless, AROM
- **Therapeutic Exercises**: Progress Phase III exercises, begin gentle resistance exercises, including resisted

scapular strengthening, rotator cuff strengthening, and deltoid strengthening

o Resistance exercises should be done 3 days/week, with rest between sessions
o **Do not do full or empty-can exercises** à **these place too much stress on the rotator cuff**

• **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature____________________________________ Date ______________________