

INSTRUCTIONS FOR SURGERY

In order to make your admission and hospital stay smooth and more pleasant, please comply with the following instructions:

- ☐ If your surgery is on **MONDAY**, please report to:

NYU Langone Orthopedic Hospital
301 East 17th Street
New York, NY 10003

If indicated by your physician, schedule your pre-surgical testing, located at

303 2nd Avenue, 1st Floor Suite 16
New York, NY 10003

- ☐ If your surgery is on **FRIDAY**, please report to:

NYU Langone Outpatient Surgery Center
339 East 38th Street
New York, NY 10016

If indicated by your physician, please call 212-263-5985 to schedule your pre-surgical testing, located at

240 East 38th St.
New York, NY 10016
Mezzanine Level

***One business day prior to your surgery, hospital staff will contact you to finalize your surgery time.**

- A. Bring jogging/warm-up pants, shorts/skirt if having knee surgery.
- B. Bring a shirt/blouse that buttons open in front instead of a pullover if having shoulder/elbow surgery.
- C. If you own crutches, bring them with you, if having knee, ankle or hip surgery.
- D. Bring all medications or a list of current medications you are taking with you. Also bring a list of any allergies.
- E. Blood pressure medication should be taken as usual with a sip of water the morning of surgery. **DO NOT** take a diuretic or fluid pill. Seizure medications may be taken before surgery.
- F. **DO NOT** take oral diabetes medications (pills) the night before or the day of surgery. If you are on insulin, **DO NOT** use insulin the morning of surgery unless you are a "problem diabetic" in which case you need to consult your physician regarding the proper insulin dose for you to use prior to surgery.

- G. Please **DO NOT** wear makeup or nail polish the day of surgery. You will need to remove contact lens (including extended wear), denture, or bridges prior to surgery. Please bring your own containers for storage.
- H. Leave all jewelry and valuables at home. The hospital will not take responsibility for lost or missing items.
- I. You need to report any skin irritation, fever, cold, etc., to Dr. Jazrawi.
- J. You will need to bring your insurance card/information with you.
- K. DO NOT eat, drink (including water), chew gum, candy, smoke cigarettes, cigars, use smokeless tobacco, etc., after midnight the night before surgery or the morning of your surgery. The only exception is a sip of water to take necessary medications the morning of surgery.
- L. You must arrange someone to drive you home when ready to leave the hospital. You will not be allowed to drive yourself home after surgery. We can assist you if you need transportation to the airport or hotel, however, you need to let us know in advance (if possible) so we can make the arrangement.
- M. NOTE: DO NOT take any aspirin, aspirin products, anti-inflammatories, Coumadin or Plavix at least 5 days prior to surgery. You are allowed to take Celebrex up to your day of surgery. If your medical doctor or cardiologist has you on any of the above medications. Please check with him/her before discontinuing the medication. You may also take Tylenol or Extra-Strength Tylenol if needed.

Nonsteroidal Anti-Inflammatory (Arthritis) Medications:

Some of the most common names for frequently used NSAID's include: Motrin, Indocin, Nalfon, Naprosyn, Naprelan, Arthrotec, Tolectin, Feledene, Voltaren, Clinoril, Dolobid, Lodine, Relafen, Daypro, Advil, Aleve, Ibuprofen.

Your first follow up appointment is usually scheduled for approximately 2 weeks after your surgery at the 333 East 38th street office. The date and time of your follow-up is _____.

If you cannot make this appointment or need to change the time, please contact the office.

If you have any questions regarding your surgery, please contact the office at 646-501-7223 option 4, option 2 or via the internet at www.newyorkortho.com

Home Supplies For Your Surgery

Laith M Jazrawi, MD

Open Surgery

- A. Open knee surgery** (ACL reconstructions, ALL (Anterolateral ligament) reconstructions, Autologous Chondrocyte Implantation, PCL reconstructions, High tibial osteotomy, Distal femoral osteotomy, Posterolateral corner reconstruction, MCL reconstruction, OATS (osteochondral autograft), Osteochondral allograft,)
 - a.** You will need 4x4 (or similar size) waterproof bandages for fourteen days. **Bandage changes for open knee surgery done post-op day #3.**
- B. Open shoulder surgery** , (Biceps Tenodeis, Latarjet, Open capsulorrhaphy, Glenoid reconstruction using Distal tibial allograft):
 - a.** You will need 4x4 (or similar size) waterproof bandages for fourteen days. Also, a box of **Bandage changes for open shoulder surgery are done post-op day #3.**
- C. Open Ankle Surgery** (Achilles Tendon Repair, Os Trigonum Excision, Ankle OCD, Modified Brostrom-Gould Procedure, Peroneus Longus/Brevis Repair)- You do not have to worry about dressing changes as your leg will be in splint/cast for the first two weeks
- D. Open Elbow surgery** (Distal Biceps Repair, LCL Reconstruction, Radial Head or Capitellum ORIF, Radial Head Replacement/Resection, Triceps Repair, UCL Reconstruction – Tommy John Surgery)- You do not have to worry about dressing changes as your arm will be in splint/cast for the first two weeks. **For Tennis Elbow surgery (lateral epicondylitis) and Golfer's Elbow Surgery (medial epicondylitis), dressing changes are are started on post-op day #3.** You will need 4x4 (or similar size) waterproof bandages for fourteen days.
- E. Hamstring repair** You will have a special dressing placed on at the time of surgery that will be kept on for the first 2 weeks after surgery. You will then need 4x4 (or similar size) Tegaderm or Telfa waterproof dressings. Also, a box of 4" by 4" gauze sponges if there is bleeding at the incision site.

Arthroscopic Surgery

- A.** For Arthroscopic shoulder, elbow, knee, or ankle surgery:
 - a.** Regular adhesive bandages ("Band-aids") can be used for arthroscopic portals x 2 weeks.
 - b.** **If biceps tenodesis was performed, use 4x4 (or similar size) waterproof bandages on wounds.**
 - c.** **In general, dressing changes for arthroscopy are done on post operative day 3**

Post-Operative Medication Administration

Knee Arthroscopy

- Pain- Motrin 800mg. 1 tab three times daily, as needed
- Adjunctive pain: Percocet (Oxycodone/Acetaminophen) 5/325 (5 tabs); One tab every 6 hours as needed for adjunctive pain*

Meniscal Repair, Meniscal Root Repair

- Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed*
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT prophylaxis- Aspirin 81mg; 2 tabs daily x 14 days
- ***** Aspirin starts post-operative day #1

Knee Ligament Reconstruction

- Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed*
- Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days
 - Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed (Max 3 tabs)
- DVT prophylaxis- Aspirin 81mg; 2 tabs daily x 28 days
- *****Antibiotics and Aspirin starts post-operative day #1

Non-weight bearing Lower Extremity Surgery (Distal Femoral Osteotomy, High Tibial Osteotomy, Tibial Tubercle Osteotomy, Cartilage Transplant)

- Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days
 - Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.
- Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed*
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed (Max 3 tabs)
- DVT prophylaxis- Aspirin 81mg; 2 tabs daily x 28 days
- *****Antibiotics and Aspirin starts post-operative day #1

Shoulder/Elbow Surgery

- Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days
 - Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.
- Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed*
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.

Ankle fracture surgery & Achilles Tendon Surgery

- Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days
 - Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.
- Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed*
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 28 days
- ****Antibiotics and Aspirin starts post-operative day #1

Ankle arthroscopy +/- Microfracture

- Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed*
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 14 days
- ****Aspirin starts post-operative day #1

Hamstring repair

- Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days
 - Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.
- Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed*
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 28 days
- ****Antibiotics and Aspirin starts post-operative day #1

*** No refills of narcotic pain medication will be given.** You must transition to over the counter Aleve or Motrin after your initial course of narcotic pain medication is completed. If you have any stomach issues you may transition to Extra Strength Tylenol instead.

***** HIGH RISK DVT Patients – patients on oral contraceptives, smokers, or history of previous DVT or embolus**

- Will receive
 - Xeralto (Rivaroxaban) 10mg; 1 tab daily x 14 days
 - Followed by aspirin 81mg; 2 tabs daily x 14 days

Post-Operative Instructions

Fasciotomy for Chronic Exertional Compartment Syndrome

Day of surgery

- A. Diet as tolerated
- B. Icing is important for the first 5-7 days post-op. While the post-op dressing is in place, icing should be done continuously. Once the dressing is removed, ice is applied for 20-minute periods 3-4 times per day. Care must be taken with icing to avoid frostbite.
- C. Pain medication as needed every 4-6 hours (refer to pain medication sheet).
- D. Make sure you have a physical therapy post-op appointment scheduled during the first week after surgery.

First Post-Operative Day

- A. Continue ice pack every 1-2 hours while awake
- B. Pain medication as needed.

Second Post-Operative Day Until Return Visit

- A. Continue ice pack as needed.
- B. Unless otherwise noted, you can bear as much weight on the affected leg as you can tolerate. Most patients use crutches or a cane for the first 1-3 days. The amount of pain you experience should be your guide for discontinuing crutch or cane use.
- C. Call our office @ 646-501-7223 option 4, option 2 to confirm your first postoperative visit, which is usually about 1-2 weeks after surgery. If you are experiencing any problems, please call our office or contact us via the internet at www.newyorkortho.com.

Third Post-Operative Day

- A. You may shower this evening. You MUST keep the extremity dry while showering. After showering, remove surgical bandage and apply fresh 4x4 surgical sponges/gauze to the incision and wrap with and ACE bandage. You will need to follow this routine for 2 weeks after surgery.
- B. No baths with leg immersed under water for 1 month after surgery.

MADE FOR NEW YORK.



Dr. Laith M. Jazrawi

Chief, Division of Sports Medicine
Associate Professor Department of Orthopaedic Surgery

Rehabilitation Guidelines Following Compartment Syndrome Release With Open Fasciotomy

Chronic Exertional Compartment Syndrome (CECS) is a painful condition of the lower leg that affects many runners and other athletes involved in repetitive impact activities. The pain associated with this condition is thought to be abnormal pressure in the compartments of the lower leg. The lower leg is comprised of four universally described compartments— anterior, lateral, superficial posterior, and deep posterior (Figure 1). Bone and connective tissue structures define the various compartments in the lower leg. The compartments have relatively fixed volumes and surround muscles, arteries, veins and nerves. Compartment syndrome occurs when increased pressure impedes blood flow thereby impairing function of tissues within the lower leg.¹ Unlike acute compartment syndrome, CECS is non-emergent. CECS is a reversible form of abnormally increased pressure in the compartment that occurs during exercise/exertion of tissues that are noncompliant with increased muscle volume during exercise.^{1,2} The exact physiological cause of CECS remains unclear but it is thought to be multi-factorial. Contributors to CECS may include: increased muscle size, connective tissue thickness or stiffness, decreased blood flow, and microtraumatic injuries.³ Factors inherent to the individual may include leg length differences and malalignment of the lower leg. Other factors may include: muscle imbalances or weakness, lack of endurance, decreased flexibility, incorrect movement control patterns, and training intensity or frequency.⁴ The incidence of CECS in those with chronic exercise-induced leg pain ranges from 14-27%.⁵ Seventy percent of patients with CECS in the anterior compartment are runners.^{1,6,7} The condition is nearly evenly split between males and females.⁷ CECS has been reported in the forearm, thigh, hand and foot however 95% of cases occur in the lower leg.⁷ Symptoms in both of the legs occur in 85-95% of those affected.⁸ Those affected with CECS often complain of dull, aching, or cramping pain localized to the compartment affected in the lower extremity at the same duration of time (minutes) following the initiation of each episode of exercise.⁹ Confirmation of the diagnosis is made with needle compartmental pressure testing at rest and following exercise.^{5,7,8,9} If rehabilitation is unsuccessful, surgical management may be the treatment choice for CECS in the active population. Specifics of surgical decompression vary, but many include: open fasciotomies or fasciotomies with partial fasciotomies.⁹ An open fasciotomy typically involves 1-2 large incisions where connective/fascial tissue is cut. A partial fasciotomy describes a procedure in which a portion of the connective tissue/fascia is removed. Surgical treatment can be performed as an outpatient procedure under local anesthesia.¹⁰ A carefully planned and implemented rehabilitation program is important for a patient to achieve optimal functional outcomes postoperatively.¹¹

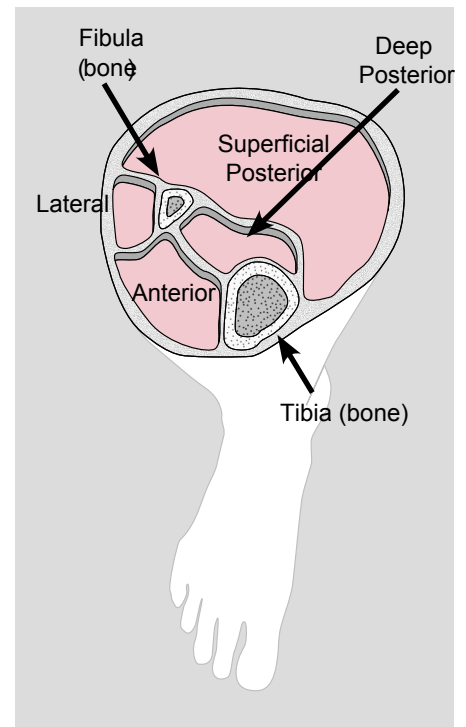


Figure 1. Lower leg compartments

Rehabilitation Guidelines Following Compartment Syndrome Release With Open Fasciotomy

Phase I (Day 1 to Day 14 after surgery)

Goals	<ul style="list-style-type: none"> ○ Pain Management ○ Prevent Swelling
Precautions	<ul style="list-style-type: none"> ○ Crutches and PWB x 2 weeks
Range of Motion Exercises	<ul style="list-style-type: none"> ○ AROM hip and knee ○ Wiggle toes, gentle ankle AROM DF/PF as tolerated
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Straight leg raises (SLR) x 4 ○ Upper body exercises (seated or bench only – no pushups) ○ LE stretches – hamstring, quads, ITB, hip flexors
Other Suggestions	<ul style="list-style-type: none"> ○ Ice and elevation

Phase II (2 weeks to 4 weeks following surgery)

Goals	<ul style="list-style-type: none"> ○ DF/PF ○ AROM WNL
Precautions	<ul style="list-style-type: none"> ○ Progress to WBAT (d/c crutches)
Range of Motion Exercises	<ul style="list-style-type: none"> ○ Continue appropriate previous exercises
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Calf pumping, alphabet, rotations ○ Gentle DF stretch w/ towel ○ Light Theraband exercises x 4 ○ Towel crunches and side-to-side ○ Seated BAPS • Stationary bike (no resistance) ○ Leg press < 25% body weight and pain-free ○ Calf press < 25% body weight and pain-free
Other Suggestions	<ul style="list-style-type: none"> ○ Compression stocking if persistent swelling ○ Ice as needed

Rehabilitation Guidelines Following Compartment Syndrome Release With Open Fasciotomy

Phase III (4 weeks to 6 weeks following surgery)

Goals	<ul style="list-style-type: none"> ○ 10 single leg heel raises ○ Normal walking gait x 1 mile
Precautions	<ul style="list-style-type: none"> ○ WBAT
Range of Motion Exercises	<ul style="list-style-type: none"> ○ Scar massage (if incision well healed) ○ Continue appropriate previous exercises
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Steamboats (Theraband x 4 while standing on involved LE) ○ Mini-squats, wall squats, total gym ○ Double leg heel raises – progress to single leg heel raises ○ Double to single leg BAPS , ball toss, and body blade ○ Treadmill – walking forwards and backwards ○ Elliptical trainer ○ Pool therapy – chest or shoulder deep water running (optional)

Phase IV (6 weeks to 12 weeks following surgery)

Goals	<ul style="list-style-type: none"> ○ Strength via weight machines 90% of non-involved ○ 45 minutes low impact cardio 5/week ○ Walk 2 miles at 15min/mile pace with minimum symptoms
Range of Motion Exercises	<ul style="list-style-type: none"> ○ Continue appropriate previous exercises
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Progressive strengthening program <ul style="list-style-type: none"> ○ Leg press and hip weight ○ Knee extension and HS curl weight machine ○ Fitter, slide board ○ Push-up progression ○ Sit-up progression ○ Progressive low-impact cardio program <ul style="list-style-type: none"> ○ Stairmaster ○ Pool therapy- unrestricted

Rehabilitation Guidelines Following Compartment Syndrome Release With Open Fasciotomy

Phase V (12 weeks to 16 weeks following surgery)

Goals	<ul style="list-style-type: none">○ Pass APFT at 4 months post-op○ Run 1 mile at 12 min/mile pace with min symptoms at 3 months
Range of Motion Exercises	<ul style="list-style-type: none">○ Continue appropriate previous exercises
Therapeutic Exercises	<ul style="list-style-type: none">○ Running progression program when following criteria met:<ul style="list-style-type: none">○ Pain-free 2 mile walk at 15min/mile pace○ No post-exercise swelling○ Transition to home/gym program 2x per week○ Agility Drills/ Plyometrics

Rehabilitation Guidelines Following Compartment Syndrome Release With Open Fasciotomy

References

1. Styf, J. Definitions and terminology. Etiology and pathogenesis of chronic compartment syndrome. In: *Compartment syndromes: diagnosis, treatment, and complications*. 2004. Boca Raton, FL. CRC Press LLC.
2. Wilder, RP. Exertional compartment syndrome. *Clin Sports Med*. 2010;29:429-435.
3. Lecocq J, Isner-Horobeti ME, Dupeyron A, et al. Exertional compartment syndrome. *Ann Readapt Med Phys*. 2004;47:334-345.
4. Anuar K, Gurumoorthy P. Systematic review of the management of chronic compartment syndrome in the lower leg. *Physiotherapy Singapore*. 2006; 9:2-15.
5. Turnipseed WD, Hurschler C, Vanderby R Jr. The effects of elevated compartment pressure on tibial arteriovenous flow and relationship of mechanical and biochemical characteristics of fascia to genesis of chronic anterior compartment syndrome. *J Vasc Surg*. 1995;21:810-816. Anuar K, Gurumoorthy P. Systematic review of the management of chronic compartment syndrome in the lower leg. *Physiotherapy Singapore*. 2006; 9:2-15.
6. Bong MR, Polatsch DB, et al. Chronic exertional compartment syndrome: diagnosis and management. *Bulletin of NYU Hosp for Jt Diseases*. Winter-Spring 2005.
7. Shah SN, Miller BS, Kuhn JE. Chronic exertional compartment syndrome. *Am Jour Ortho*. 2004;335-341.
8. Gill CS, Halstead ME, Matava MJ. Chronic exertional compartment syndrome of the leg in athletes: evaluation and management. *Physician and Sportsmed*. 2010;38:1-7.
9. Wittstein J, Moorman CT III, Levin LS. Endoscopic compartment release for chronic exertional compartment syndrome. *Am Jour Sports Med*. 2010;20:1-6.
10. Hutchinson MR, Lloyd Ireland M. Common compartment syndromes in athletes: treatment and rehabilitation. *Sports Med*. 1994;17:200-208.
11. Kisner, C, Colby LA. Surgical interventions and postoperative management, the ankle and foot. In: *Therapeutic Exercise: Foundations and Techniques*. 5th Edition. 2007. Philadelphia, PA. F. A. Davis Company.
12. Schubert, AG. Exertional Compartment Syndrome: Review of the Literature and Proposed Rehabilitation Guidelines Following Surgical Release. *Intern Jour Sports Phys Ther*. 2011; 6: 126-141.

Post-Operative Rehabilitation Protocol: Fasciotomy for Chronic Exertional Compartment Syndrome

Patient Name: _____ Date: _____

Days 1-14:

- Crutches and PWB x 2 weeks
- AROM hip and knee
- Wiggle toes, gentle ankle AROM DF/PF as tolerated
- Straight leg raises (SLR) x 4
- Upper body exercises (seated or bench only - no pushups)
- LE stretches - hamstring, quads, ITB, hip flexors
- Ice and elevation

Goals:

- Pain management
- Prevent swelling

Weeks 2-4:

- Progress to WBAT (d/c crutches)
- Continue appropriate previous exercises
- Calf pumping, alphabet, rotations
- Gentle DF stretch w/ towel
- Light Theraband exercises x 4
- Towel crunches and side-to-side
- Seated BAPS
- Stationary bike (no resistance)
- Leg press < 25% body weight and pain-free
- Calf press < 25% body weight and pain-free
- Ice as needed
- Compression stocking if persistent swelling

Goals:

- DF/PF
- AROM WNL

Weeks 4-6:

- WBAT
- Continue appropriate previous exercises
- Scar massage (if incision well healed)
- Theraband exercises x 4 – gradually increase resistance
- Steamboats (Theraband x 4 while standing on involved LE)
- Mini-squats, wall squats, total gym
- Double leg heel raises – progress to single leg heel raises
- Double to single leg BAPS, ball toss, and body blade
- Treadmill – walking forwards and backwards
- Elliptical trainer
- Pool therapy – chest or shoulder deep water running (optional)

Goals:

- 10 single leg heel raises
- Normal walking gait x 1 mile

Weeks 6-12:

- Continue appropriate previous exercises
- Progressive strengthening program
 - Leg press and hip weight machine
 - Knee extension and HS curl weight machine
 - Fitter, slide board
 - Push-up progression
 - Sit-up progression
- Progressive low-impact cardio program
 - Treadmill – walking progression program
 - Stairmaster
 - Pool therapy - unrestricted

Weeks 12-16:

- Continue appropriate previous exercises
- Running progression program when following criteria met:
 - 3 x 20 heel raises with LE strength 90% of uninjured
 - Pain-free 2 mile walk at 15min/mile pace
 - No post-exercise swelling
- Agility drills/plyometrics
- Transition to home/gym program 2x per week

Goals:

- 45 min low-impact cardio 5/week
- Strength via weight machines
90% of non-injured

- Walk 2 miles at 15min/mile pace
with minimum symptoms

Goals:

- Run 1 mile at 12min/mile pace
with min symptoms at 3 months
- Pass APFT at 4 months post-op

Comments:**Signature:** _____**Date:** _____

PHYSICAL THERAPY LOCATIONS

*****Please schedule your post-operative physical therapy appointments BEFORE your surgery*****

Manhattan Sports and Manual Physical Therapy

10 East 33rd Street, 2nd Floor
 New York, NY 10016
 (646) 487-2495
www.msmpt.com

NYU Langone Orthopedic Center PT

333 E 38th St, 5th Floor
 New York, NY 10016
 (646) 501-7077

Other Locations:

BROOKLYN				
R.P.T. Physical Therapy	335 Court Street	Cobble Hill	11231	(718) 855-1543
One on One PT	2133 Ralph Ave	Flatlands	11234	(718) 451-1400
One on One PT	17 Eastern Parkway	Prospect Heights	11238	(718) 623-2500
One on One PT	9920 4th Ave	Bay Ridge	11209	(718) 238-9873
One on One PT	1390 Pennsylvania Ave	Canarsie	11239	(718) 642-1100
One on One PT	1715 Avenue T	Sheepshead Bay	11229	(718) 336-8206

MANHATTAN-DOWNTOWN				
Health SOS	594 Broadway	New York	10012	(212) 343-1500
Occupational & Industrial Orthopaedic Center	63 Downing Street	New York	10014	(212) 255-6690
Promobility	401 Broadway	New York	10013	(646) 666-7122

MANHATTAN -EAST SIDE				
Harkness Center for Dance (PT Service)	614 Second Ave	New York	10003	(212) 598-6054
RUSK at the Men's Center	555 Madison Ave	New York	10022	(646) 754-2000
RUSK Physical Therapy	240 E. 38th Street	New York	10016	(212) 263-6033
STAR Physical Therapy	160 E. 56th Street	New York	10022	(212) 355-7827

Therapeutic Inspirations	144 E. 44th St	New York	10017	(212) 490-3800
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MANHATTAN UPPER EAST SIDE

Health SOS	139 E. 57th Street	New York	10022	(212) 753-4767
Premier PT	170 E. 77th Street	New York	10021	(212) 249-5332
Rusk PT at Women 's Health Center	207 E. 84th Street	New York	10028	(646) 754-3300
SPEAR PT	120 E. 56th Street	New York	10022	(212) 759-2211
Sports PT of NY	1400 York Ave	New York	10021	(212) 988-9057

MANHATTAN UPPER WEST SIDE

Premier PT	162 W. 72nd Street	New York	10023	(212) 362-3595
Sports PT of NY	2465 Broadway	New York	10025	(212) 877-2525

MANHATTAN WEST SIDE

Sports Medicine at Chelsea	22 West 21st Street Suite 400	New York	10010	(646) 582-2056
Chelsea Physical Therapy & Rehabilitation	119 W. 23rd Street	New York	10011	(212) 675-3447
SPEAR Physical Therapy	36 W. 44th Street	New York	10036	(212) 759-2280

QUEENS

Ergo Physical Therapy P.C.	107-40 Queens Blvd	Forest Hills	11375	(718) 261-3100
Susan Schiliro, PT (Hand & Upper Extremity only)	99-32 66th Road	Rego Park	11374	(718) 544-1937

STATEN ISLAND

One on One PT	31 New Dorp Lane 1 st , Floor	Staten Island	10306	(718) 979-4466
One on One PT	33 Richmond Hill Rd	Staten Island	10314	(718) 982-6340

LONG ISLAND

Health SOS	375 Deer Park Ave	Babylon	11702	(631) 321-6303
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Hand in Hand Rehabilitation (Hand & Upper Extremity only)	346 Westbury Ave	Carle Place	11514	(516) 333-1481
Home PT Solutions	111 W. Old Country Rd.	Hicksville	11801	(516) 433-4570
Bi-County Physical Therapy & Rehabilitation	270-03 Hillside Ave	New Hyde Park	11040	(718) 831 - 1900
Bi-County Physical Therapy & Rehabilitation	397 Willis Ave	Williston Park	11596	(516) 739-5503

WESTCHESTER

Health SOS	1015 Saw Mill River	Ardsley	10502	(914) 478-8780
Premier PT	223 Katonah Ave	Katonah	10536	(914) 232-1480
PRO Sports PT of Westchester	2 Overhill Road	Scarsdale	10583	(914) 723-6987
Westchester Sports Physical Therapy, PC	672 White Plains Road	Scarsdale	10583	(914) 722-2400
Rye Physical Therapy and Rehabilitation	411 Theodore Fremd Ave	Rye	10580	(914) 921-6061
Rye Physical Therapy and Rehabilitation	15 North Broadway; Suite K	White Plains	10601	(914) 686-3132

CONNECTICUT

Premier PT	36 Old Kings Hwy S	Darien	06820	(203) 202-9889
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NEW JERSEY

Jersey Central Physical Therapy & Fitness	21 47 Route 27	Edison	08817	(732) 777-9733
Jag PT	34 Mountain Blvd	Warren	07059	(908) 222-0515
Jag PT	622 Eagle Rock Ave	West Orange	07052	(973) 669-0078