



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 Hospital for Joint Diseases
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.

Center for Musculoskeletal Care 333 E. 38th St, New York, NY 10016
Tel: (646) 501-7223/ Fax: (646) 754-9505 / www.NewYorkOrtho.com



- 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 M.D.

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 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) 10/325; 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.
- Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- 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.
- Breakthrough Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- 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.
- DVT prophylaxis- Aspirin 81mg; 2 tabs daily x 14 days
- *****Antibiotics and Aspirin start 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.
- Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT prophylaxis- Aspirin 81mg; 2 tabs daily x 14 days
- *****Antibiotics and Aspirin start 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.
- Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 14 days

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.
- Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 14 days
- ****Antibiotics and Aspirin start POD #1

Ankle arthroscopy +/- Microfracture and Achilles repair

- 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.
- Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.
- Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.
- DVT Prophylaxis - Aspirin 81mg; 2 tabs daily x 14 days
- ****Antibiotics and Aspirin start POD #1

Post-Operative Instructions

Modified Brostrom-Gould Procedure

Day of Surgery

- A. Diet as tolerated.
- B. Pain medication as needed every 6 hours.
- C. Icing is important for the first 5-7 days post-op. Ice is applied for 20-minute periods 3-4 times per day. Care must be taken with icing to avoid frostbite.
- D. Set up your physical therapy appointment for 4 weeks after surgery
- E. **Keep leg elevated above heart**

First Post-Operative Day

- A. Continue icing
- B. You will need to keep your cast/splint dry when taking a shower. Do this for about 4 weeks after surgery.

Second Post-Operative Day until return visit

- A. Continue icing
- B. Leg elevation as much as possible

Ankle Support

- A. Weeks 0-2: posterior slab/splint
- B. Weeks 2-4: short leg cast
- C. Weeks 4-6 Aircast walking boot weightbearing as tolerated. ROM exercises in PT
- D. Weeks 6-8: wean out of boot

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.

Dr. Laith M. Jazrawi

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

Rehabilitation After Brostrom-Gould Procedure

The ankle is a very complex joint. There are actually three joints that make up the ankle complex: the tibiotalar joint, the subtalar joint and the distal tibiofibular joint. Stability of a joint is maintained by connective tissue structures and the dynamic support of the surrounding muscles. The primary stabilizing connective tissues are ligaments. A ligament connects bone to bone to limit excessive movement. The outside (lateral) ankle complex is stabilized at each of the three joints by three major ligaments. The tibiotalar joint is stabilized by the anterior talofibular (ATFL) ligament. The subtalar joint is stabilized by the calcaneofibular (CF) ligament and the tibiofibular joint is stabilized by the anterior and posterior tibiofibular (ATFL and PTFL) ligaments (Figure 1).

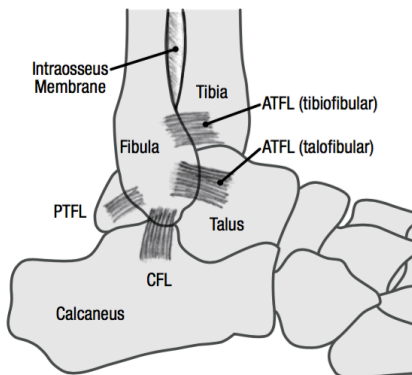


Figure 1

The muscles of the lower leg, ankle and foot also help to stabilize the ankle joint dynamically. When the ankle complex starts to move excessively in one direction, reactive corrective firing of the opposite muscle groups can help stabilize the joint. The muscles that are primarily responsible for preventing lateral ankle sprains are the peroneus longus and brevis (Figure 2). The ability for these muscles to react quickly is not only related to their strength but more importantly by proprioception, which is the body's ability to sense the position of the joint and subsequently correct it as necessary by sending nerve impulses to the appropriate muscles. Proprioception can be enhanced or trained with the use of balance exercises so these are commonly used in ankle sprain prevention and rehabilitation programs.

Lateral ankle sprains are very common, especially in sports such as basketball and volleyball. Generally athletes recover well from this type of injury with physical therapy and rehabilitation. However, up to 20% of lateral ankle sprains can lead to chronic pain and instability. This instability may occur via repetitive

ankle sprains or even progress to the ankle giving way with routine daily activities. Aggressive rehabilitation, bracing, taping and orthotics are all non-surgical options that may be appropriate to prevent instability.

If these measures fail to control the instability it may be necessary to restore the anatomy of the lateral ankle with surgical reconstruction. The preferred surgical method is to perform an anatomic repair of the anterior talofibular and calcaneofibular ligaments via a technique called the Brostrom repair, which involves shortening the attenuated ligaments and a direct repair with suture fixation. When the anatomical repair is reinforced with the advancement of the inferior extensor retinaculum, it is called the modified Brostrom repair. When the repair is further augmented with a slip of the peroneus brevis tendon through a drill hole in the fibula it is referred to as a modified Brostrom-Evans technique. The peroneus brevis tendon then acts as a check to inversion stresses and provides reinforcement to the anatomical repair without limiting long-term inversion/eversion motion or strength. For revision surgeries or in the

(continued)

Rehabilitation After Brostrom-Gould Procedure

case of excessive instability, an allograft (cadaver tissue, usually a tendon) may be needed to reconstruct both the anterior talofibular and calcaneofibular ligaments.

After surgery, rehabilitation with a physical therapist or athletic trainer is needed to restore range of motion,

strength, proprioception, movement control and guide the athlete's return to sport. The rehabilitation guidelines are presented in a criterion based progression. Specific time frames, restrictions and precautions are given to protect healing tissues and the surgical repair/reconstruction. General time frames are also given for

reference to the average individual, but individual patients will progress at different rates depending on their age, associated injuries, pre-injury health status, rehabilitation compliance and injury severity. The technique used for reconstruction may alter the rehabilitation as well.

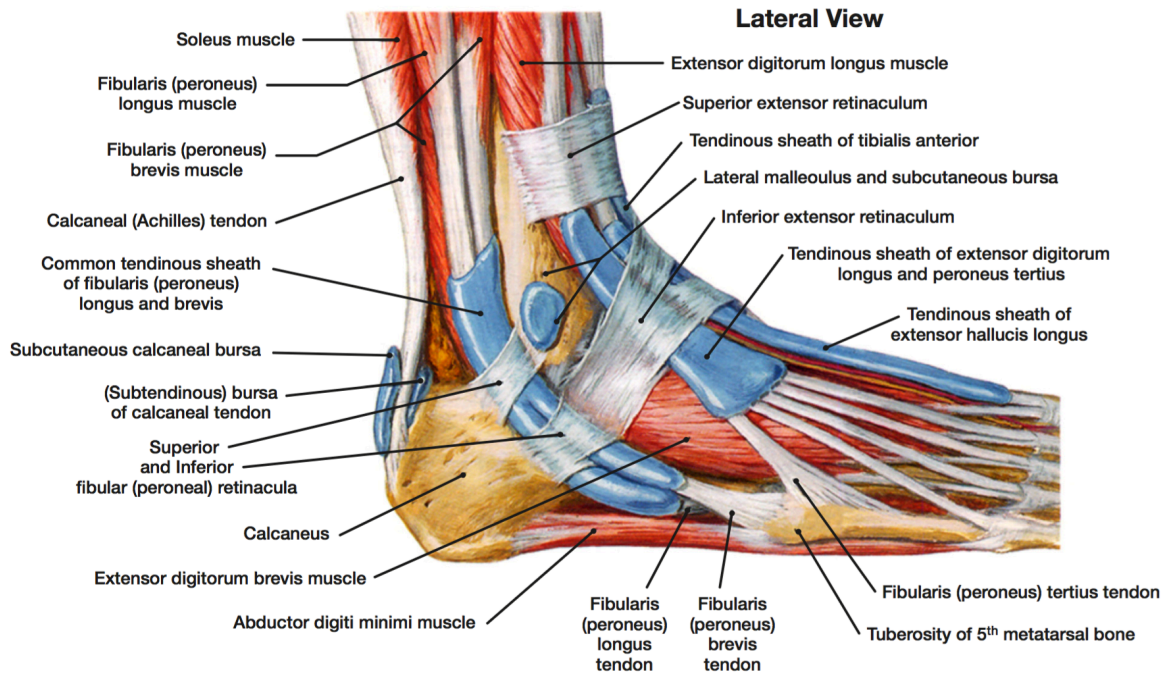


Figure 2

Rehabilitation After Brostrom-Gould Procedure

Phase I (Surgery to 4 weeks after surgery)

Goals	<ul style="list-style-type: none"> ○ Protect healing tissue ○ Decrease pain and inflammation ○ Retard muscular atrophy ○ Control weight-bearing forces
Precautions	<ul style="list-style-type: none"> ○ Weight-bearing: partial weight-bearing in cast with 2 crutches for first 4 weeks
Range of Motion Exercises	<ul style="list-style-type: none"> ○ None
Therapeutic Exercises	<ul style="list-style-type: none"> ○ NO INVERSION EXERCISES ○ No strengthening for first 4 weeks ○ Begin submaximal isometrics at 4 weeks ○ Hip abduction/adduction ○ Straight leg raises into flexion ○ Remove cast week 4 and place in cam walker

Phase II (4 weeks to 12 weeks following surgery)

Goals	<ul style="list-style-type: none"> ○ Protect healing tissue ○ Retard muscular atrophy ○ Progress weight-bearing tolerance ○ Begin proprioceptive drills
Precautions	<ul style="list-style-type: none"> ○ Weight-bearing as tolerated in cam walker weeks 4-8 ○ Discontinue cam walker at end of week 8 ○ Place in air cast for 3 additional weeks
Range of Motion Exercises	<ul style="list-style-type: none"> ○ Begin passive dorsiflexion, plantar flexion and eversion ○ No active INVERSION past neutral for 12 weeks
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Begin strengthening exercises <ul style="list-style-type: none"> ○ PRE's at 75% of opposite LE (Theraband) ○ Emphasize eversion and peroneal strengthening (Theraband) ○ Continue above exercises and begin bicycle ○ Week 6-8 <ul style="list-style-type: none"> ○ 3-way Theraband isotonic (dorsiflexion, plantarflexion, eversion) ○ Seated proprioceptive drills ○ Leg press ○ Knee extension ○ Week 8-9 <ul style="list-style-type: none"> ○ Vertical squats ○ Side and front lunges ○ Lateral step-ups ○ Week 10-12 <ul style="list-style-type: none"> ○ Standing proprioception drills ○ Stair climbing machine ○ Pool Program <ul style="list-style-type: none"> ○ Swimming week 6-8 ○ Fast-paced walking week 8-10 ○ Running in pool week 10-12

Rehabilitation After Brostrom-Gould Procedure

Phase III – Advanced Motion and Strengthening Phase (12 weeks to 20 weeks following surgery)

Goals	<ul style="list-style-type: none"> ○ Progress to full motion ○ Advance proprioceptive drills ○ Increase strength, power, and endurance ○ Gradually initiate sporting activities
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Continue strengthening exercises ○ Theraband strengthening inversion/eversion, dorsi/plantarflexion ○ Towel gathering ○ Standing toe-calf raises ○ Bicycle ○ Stairclimber ○ Vertical squats ○ Front lunges ○ Proprioceptive training ○ Initiate Plyometric program <ul style="list-style-type: none"> ○ Running program ○ Agility drills ○ Sports specific training and drills

Phase IV – Return to Activity Phase (5 to 6 months after surgery)

Goals	<ul style="list-style-type: none"> ○ Continue to increase strength, power, and endurance of lower extremity ○ Gradual return to sports activities
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Begin light running program ○ Continue isokinetic (light speed, full ROM) o Continue eccentrics ○ Continue mini squats/lateral step-ups ○ Continue closed kinetic rehabilitation ○ Continue endurance exercises

Phase V – Return to Activity (over 6 months after surgery)

Goals	<ul style="list-style-type: none"> ○ Advance rehabilitation to competitive sports ○ Achieve maximal strength and further enhance neuromuscular coordination and endurance
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Continue <ul style="list-style-type: none"> ○ Strengthening program ○ Closed chain strengthening program ○ Plyometric program ○ Running and agility program ○ Accelerate sport specific training and drills

Postoperative Rehabilitation Following Modified Brostrom-Gould Procedure

Name: _____

Date: _____

Diagnosis: _____

Date of Surgery: _____



IMMEDIATE PROTECTION PHASE (week 0-4)

- **Goals**
 - Protect healing tissue
 - Decrease pain and inflammation
 - Retard muscular atrophy
 - Control weight-bearing forces
- **Weight-bearing:** partial weight-bearing in cast with 2 crutches for first 4 weeks
- **ROM:** none
- **NO INVERSION EXERCISES**
- **Exercises**
 - No strengthening for first 4 weeks
 - Begin submaximal isometrics at 4 weeks
 - Hip abduction/adduction
 - Straight leg raises into flexion
 - Remove cast week 4 and place in cam walker



Phase II -INTERMEDIATE PHASE (Week 4-12)

- **Goals:**
 - Protect healing tissue
 - Retard muscular atrophy
 - Progress weight-bearing tolerance
 - Begin proprioceptive drills
- **Weightbearing:**
 - Weight-bearing as tolerated in cam walker weeks 4-8
 - Discontinue cam walker at end of week 8
 - Place in air cast for 3 additional weeks
- **ROM:** begin passive dorsiflexion, plantarflexion and eversion
- **No active INVERSION past neutral for 12 weeks**
- **Begin strengthening exercises**
 - PRE's at 75% of opposite LE (Theraband)
 - Emphasize eversion and peroneal strengthening (Theraband)
 - Continue above exercises and begin bicycle
- **Week 6-8**
 - 3-way Theraband isotonic (dorsiflexion, plantarflexion, eversion)
 - Seated proprioceptive drills
 - Leg press
 - Knee extension
- **Week 8-9**
 - Vertical squats
 - Side and front lunges
 - Lateral step-ups



- **Week 10-12**
 - Standing proprioceptive drills
 - Stair climbing machine
- **Pool Program**
 - Swimming week 6-8
 - Fast-paced walking week 8-10
 - Running in pool week 10-12



Phase III –ADVANCED MOTION AND STRENGTHENING PHASE (Week 12-20)

- **Goals:**
 - Progress to full motion
 - Advance proprioceptive drills
 - Increase strength, power, and endurance
 - Gradually initiate sporting activities
- **Exercises**
 - Continue strengthening exercises
 - Theraband strengthening inversion/eversion, dorsi/plantarflexion
 - Towel gathering
 - Standing toe-calf raises
 - Bicycle
 - Stairclimber
 - Vertical squats
 - Front lunges
 - Proprioceptive training
- **Initiate Plyometric Program**
 - Initiate:
 - Running program
 - Agility drills
 - Sport specific training and drills



Phase IV –RETURN TO ACTIVITY PHASE (Month 5-6)

- **Goals:**
 - Continue to increase strength, power, and endurance of lower extremity
 - Gradual return to sport activities
- **Exercises**
 - Begin light running program
 - Continue isokinetic (light speed, full ROM)
 - Continue eccentrics
 - Continue mini squats/lateral step-ups
 - Continue closed kinetic rehabilitation
 - Continue endurance exercises





Phase V –Return to Activity (Month 5-6)

- **Goals**
 - Advance rehabilitation to competitive sports
 - Achieve maximal strength and further enhance neuromuscular coordination and endurance
- **Exercises**
 - Continue
 - Strengthening program
 - Closed chain strengthening program
 - Plyometric program
 - Running and agility program
 - Accelerate sport specific training and drills

Comments:

Frequency: _____ times per week

Duration: _____ weeks

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.msmt.com

Center for Musculoskeletal Care 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