Laith M Jazrawi, MD
Professor of Orthopedic Surgery
Chief, Division of Sports Medicine
T 646-501-7223

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.

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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

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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

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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.

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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

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Post-Operative Instructions
Open Anterior Capsulorrhaphy

Day of Surgery

A. Relax. 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 on the first or second day, ice is applied for 20-minute periods 3-4 times per day. Care must be taken with icing to avoid frostbite.

You will be contacted by East Coast Orthotics regarding an ice compression unit to be used after surgery. This helps with pain and swelling but typically is not covered by insurance. The cost is $200-300 for a 2-week rental. Alternatively, ice gel packs with a shoulder or knee sleeve can be provided by the hospital for a minimal charge.

C. Pain medication as needed every 6 hours (refer to pain medication sheet)

First Post-Operative Day

A. Continue ice pack everyone to two hours while awake and pain meds as needed or cryocuff or gameready. Ice cuff as per instructions.

Second Post-Operative Day

A. Continue ice pack up to post op day 2-5 and utilize after physical therapy sessions.

Third Post-Operative Day

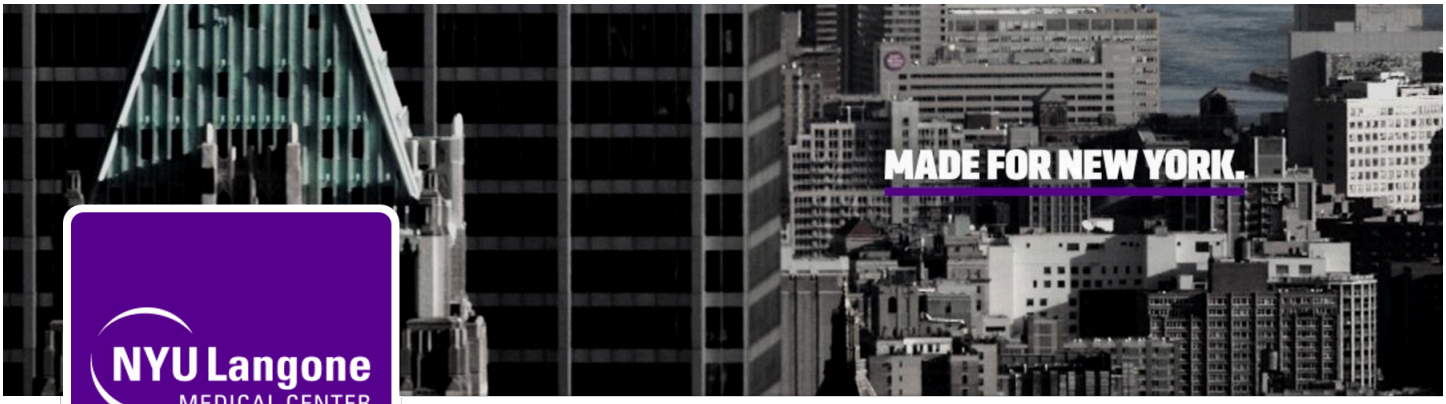
A. You may remove surgical bandage and shower this evening. Apply 4x4 (or similar size) waterproof bandage to these wounds prior to showering and when showering is complete apply fresh waterproof bandage. You will need to follow this routine for 2 weeks after surgery.

Physical Therapy

A. Physical Therapy should begin at 4 weeks. Please call your preferred facility to make an appointment.
B. Pendulum exercises should begin after the first postoperative follow-up visit.

**Note: Your shoulder will be very swollen. It may take a week or longer for this to go away. It is also common to notice burning around the shoulder as the swelling resolves. If excessive bleeding occurs, please notify Dr. Jazrawi.*

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.



NYU Langone MEDICAL CENTER

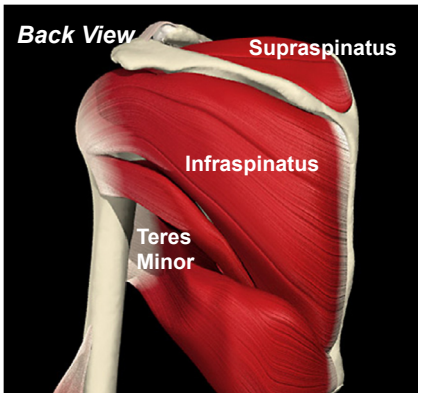
Dr. Laith M. Jazrawi

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

Rehabilitation Guidelines for Arthroscopic Capsular Shift

The anatomic configuration of the shoulder joint (glenohumeral joint) is often compared to a golf ball on a tee. This is because the articular surface of the round humeral head is approximately four times greater than that of the relatively at shoulder blade face (glenoid fossa)[1] (Figure 1). The stability and movement of the shoulder is controlled by the rotator cuff muscles, as well as the shoulder ligaments, the capsule of the shoulder and the glenoid labrum. The labrum is a fibrocartilagenous ring which attaches to the bony rim of the glenoid fossa.1 The labrum doubles the depth of the glenoid fossa to help provide stability.[2] An analogy would be a parked car on a hillside with a block under the tire — the round tire bThe anatomic configuration of the shoulder joint (glenohumeral joint) is often compared to a golf ball on a tee. This is because the articular surface of the round humeral head is approximately four times greater than that of the relatively flat shoulder blade face (glenoid fossa).1 The stability and movement of the shoulder is controlled by the rotator cuff muscles, ligaments, and the capsulolabral complex of the shoulder (Figure 1). The labrum is a fibrocartilagenous ring, which attaches to the bony rim of the glenoid fossa. The labrum doubles the depth of the glenoid fossa to help provide stability. An analogy includes a parked car on a hillside with a chop block under the tire such that the round tire is the humeral head, the road is the glenoid fossa and the chop block is the labrum. The anatomy of the shoulder allows for great mobility, yet this anatomical structure also sacrifices stability. The shoulder is one of the most commonly dislocated joints in the body. Shoulder dislocations can occur from trauma, such as falling on an outstretched hand. When this happens it is common for the capsule and ligaments to be torn, which often includes a large tear of the glenoid labrum. The type of labral tears in which a large piece of the labrum looses its connection to the glenoid fossa are called Bankart lesions.

Shoulder dislocations often lead to recurrent dislocation or subluxation, and posterior shoulder instability occurs when the humeral head subluxes or dislocates in relationship to the glenoid. Shoulder instability may involve the front of the shoulder, and then is referred to as anterior instability. When it occurs in the back of the shoulder it is referred to as posterior instability and when it occurs toward the bottom of the shoulder it is referred to as inferior instability. Complete shoulder dislocations or subluxations (also termed as a partial dislocation of the joint) can also be caused by "hyperlaxity" (genetic or acquired looseness of the shoulder capsule and ligaments). Hyperlaxity often affects the shoulder in more than one direction, which is referred to as multi-directional instability.



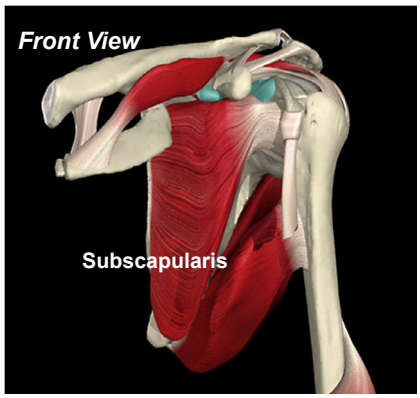


Figure 1 *Rotator cuff anatomy*

Rehabilitation Guidelines for Arthroscopic Capsular Shift

This often occurs without a true Bankart lesion. For some athletes multi-directional instability can be treated nonoperatively with rehabilitation. This often involves strengthening the rotator cuff and scapular muscles, as well as improving the body's neuromuscular reaction to sudden changes of position or movement. When these approaches are unsuccessful and instability continues, the athlete may be left with the option of changing sports or having surgery. Surgical correction for multi-directional instability consists of tightening the capsule and ligamentous tissue by reducing the "looseness" or size of the capsule. This is usually done by taking "tucks" in the capsule with suture material. After surgery, rehabilitation plays a crucial role in maximizing the patient's functional outcome. In the early phases after surgery it is necessary to protect the surgical repair to allow healing. This is done by only allowing the patient to move the shoulder through certain ranges of motion and wear a sling most of the time that they are not doing rehabilitation exercises. The range of motion restrictions can be seen in Phase I below. The rehabilitation guidelines are presented in a criterion based progression. General time frames are given for reference to the average, but individual patients will progress at different rates depending on their age, associated injuries, pre-injury health status, rehab compliance and injury severity. Specific time frames, restrictions and precautions may also be given to protect healing tissues and the surgical repair/reconstruction.

Rehabilitation Guidelines for Arthroscopic Capsular Shift

Phase I (Surgery to 6 weeks after surgery)

Goals	Allow healing of sutured capsule. Begin early protected and restricted range of motion. Retard muscular atrophy and enhance dynamic stability. Decrease pain/inflammation. Improve strength. Gradual increase in ROM. Normalize arthrokinematics.
Precautions	Brace: patients are in shoulder immobilizer for 4-6 weeks. Sleep in sling for 4 weeks. No overhead activities for 3 weeks. Compliance to rehab program is critical.
Range of Motion Exercises	L-bar active assisted exercises, gentle PROM exercises ER to 25-30 degrees in scapular plane IR to 30-35 degrees in scapular plane Shoulder flexion to 105-115 degrees Shoulder elevation in scapular plane to 115 degrees Rope and pulley flexion All exercises performed to tolerance and therapist/physician motion guidelines Take to point of pain and/or resistance and hold GENTLE self-capular stretches
Therapeutic Exercises	Gentle Joint Mobilization to Re-establish Normal Arthrokinematics to: Scapulothoracic joint Glenohumeral joint Sternoclavicular joint Strengthening Exercises Isometrics Rhythmic stabilization exercises May initiate tubing for ER/IR at 0 degrees Conditioning Program for: Trunk Gripping exercises with putty Elbow and wrist flex/extension and pronation/supination Pendulum exercises (non-weighted) No shoulder abuction or extension AROM cervical spine Shoulder isometrics--Flexors, extensors, ER, ABD No active or active assisted IR x 6 weeks
Other Suggestions	Decrease Pain/Inflammation Ice, NSAID, modalities

Rehabilitation Guidelines for Arthroscopic Capsular Shift

Phase II (7 weeks to 12 weeks following surgery)

Goals	Full non-painful ROM at week 10-12 Normalize arthrokinematics Increase strength Improve neuromuscular control
Range of Motion Exercises	Progress ROM to full ROM as tolerated ER at 90 degrees ABD: 80-85 degrees IR at 90 degrees ABD: 70-75 degrees Flexion to 165-170 degrees L-Bar active assisted exercises at 60-90 degree ABD Continue all exercises listed above Gradually increase ROM to full ROM week 12 Continue self-capsular stretches Continue joint mobilization May initiate IR/ER ROM at 90 degrees of abduction
Therapeutic Exercises	Initiate Neuromuscular Control Exercises for Scapulothoracic Joint Initiate isotonic dumbbell program Side-lying ER/IR Shoulder abduction Supraspinatus Latissimus dorsi Rhomboids Biceps/triceps curls Shoulder shrugs Push-ups into chair (serratus anterior) Continue tubing at 0 degrees for ER/IR Continue stabilization exercises for the glenohumeral joint Continue all exercises listed above; emphasize neuromuscular control drills and scapular strengthening Initiate tubing exercises for rhomboids, latissimus dorsi, biceps and triceps

Phase III (12 weeks to 20 weeks following surgery)

Goals	Improve strength/power/endurance Improve neuromuscular control Prepare athletic patient for gradual return to sports
Range of Motion Exercises	Fundamental shoulder exercises Emphasis: neuromuscular control drills, PNF rhythmic stabilization, rotator cuff strengthening and scapular strengthening Continue tubing exercises for ER/IR at 0 degrees ABD (arm at side)
Therapeutic Exercises	Continue isotonics for: Rhomboids Latissimus dorsi Biceps Dumbbell exercises for supraspinatus and deltoid Continue serratus anterior strengthening exercises push-ups floor Continue trunk/LE strengthening exercises Continue neuromuscular exercises Continue self-capsular stretches

Rehabilitation Guidelines for Arthroscopic Capsular Shift

Phase IV (20 weeks to 28 weeks following surgery)

Goals	Progressively increase activities to prepare patient for full functional return Emphasis on gradual return to recreational activities
Precautions	Criteria to Progress to Phase IV: Full ROM No pain or tenderness Satisfactory clinical exam
Therapeutic Exercises	Initiate interval sports programs (if patient is a recreational athlete) Continue tubing exercises listed in Phase III Continue all strengthening exercises Continue ROM exercises

References

1. Bell JE. Arthroscopic management of multidirectional instability. Orthop Clin North Am. 2010 Jul; 41(3):357-65.

2. Bigliani LU, Kurzweil PR, Schwartzbach CC, Wolfe IN, Flatow EL. Inferior capsular shift procedure for anterior-inferior shoulder instability in athletes. Am J Sports Med. 1994 Sep-Oct;22(5):578-84.

3. Duncan R, Savoie FH 3rd. Arthroscopic inferior capsular shift for multidirectional instability of the shoulder: a preliminary report. Arthroscopy. 1993;9(1):24-7.

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Open Anterior Capsular Shift Rehabilitation Protocol

Name: _____ **Date:** _____

Diagnosis: _____ **Date of Surgery:** _____

☐ **Phase I (Weeks 0-6)**

- Protection Phase
  - Goals: Allow healing of sutured capsule
  - Begin early protected and restricted range of motion
  - Retard muscular atrophy and enhance dynamic stability
  - Decrease pain/inflammation
  - Brace: Patients are place in shoulder immobilizer for 4-6 weeks
- Week 0-3
  - Precautions:
    - Sleep in sling for 4 weeks
    - No overhead activities for 3 weeks. Compliance to rehab program is critical.
  - Exercises:
    - Gripping exercises with putty
    - Elbow and wrist flex/extension and pronation/supination
    - Pendulum exercises (non-weighted)
      - No shoulder abuction or extension
      - AROM cervical spine
      - Shoulder isometrics-Flexors, extensors, ER, ABD
    - No active or active assisted IR x 6 weeks
- Week 4-6
  - Goals:
    - Gradual increase in ROM
    - Normalize arthrokinematics
    - Improve strength
    - Decrease pain/inflammation
  - Range of Motion Exercises
    - L-bar active assisted exercises, gentle PROM exercises
      - ER to 25-30 degrees in scapular plane
      - IR to 30-35 degrees in scapular plane
      - Shoulder flexion to 105-115 degrees
      - Shoulder elevation in scapular plane to 115 degrees
      - Rope and pulley flexion
    - *All exercises performed to tolerance and therapist/physician motion guidelines
    - *Take to point of pain and/or resistance and hold
    - *GENTLE self-capular stretches
  - Gentle Joint Mobilization to Re-establish Normal Arthrokinematics to:
    - Scapulothoracic joint
    - Glenohumeral joint
    - Sternoclavicular joint
  - Strengthening Exercises
    - Isometrics
    - Rhythmic stabilization exercises
    - May initiate tubing for ER/IR at 0 degrees

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- Conditioning Program for:
  - Trunk
  - Lower extremities
  - Cardiovascular
- Decrease Pain/Inflammation
  - Ice, NSAID, modalities

☐ **Phase II (Weeks 7-12)**

- Intermediate Phase
  - Goals:
    - Full non-painful ROM at week 10-12
    - Normalize arthrokinematics
    - Increase strength
    - Improve neuromuscular control
- Week 7-8
  - Range of Motion Exercises
    - L-Bar active assisted exercises at 60-90 degree ABD
    - Continue all exercises listed above
    - Gradually increase ROM to full ROM week 12
    - Continue self-capsular stretches
    - Continue joint mobilization
    - May initiate IR/ER ROM at 90 degrees of abduction
  - Strength Exercises
    - Initiate isotonic dumbbell program
    - Side-lying ER/IR
    - Shoulder abduction
    - Supraspinatus
    - Latissimus dorsi
    - Rhomboids
    - Biceps/triceps curls
    - Shoulder shrugs
    - Push-ups into chair (serratus anterior)
    - Continue tubing at 0 degrees for ER/IR
    - Continue stabilization exercises for the glenohumeral joint
  - Initiate Neuromuscular Control Exercises for Scapulothoracic Joint
- Week 8-10
  - Continue all exercises listed above, emphasize neuromuscular control drills and scapular strengthening
  - Initiate tubing exercises for rhomboids, latissimus dorsi, biceps and triceps
  - Progress ROM to full ROM as tolerated
    - ER at 90 degrees ABD: 80-85 degrees
    - IR at 90 degrees ABD: 70-75 degrees
    - Flexion to 165-170 degrees

☐ **Phase III (Weeks 12-20)**

- Dynamic Strengthening Phase
- Week 12-17
  - Goals:
    - Improve strength/power/endurance
    - Improve neuromuscular control
    - Prepare athletic patient for gradual return to sports
  - <u>Criteria to Enter Phase III:</u>

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- Full non-painful ROM
- No pain or tenderness

- Emphasis of Phase III
  - Dynamic stabilization exercises
  - Eccentric exercises
  - Diagonal patterns, functional movements
- Exercises
  - Fundamental shoulder exercises
  - Emphasis: neuromuscular control drills, PNF rhythmic stabilization, rotator cuff strengthening and scapular strengthening
  - Continue tubing exercises for ER/IR at 0 degrees ABD (arm at side)
  - Continue isotonics for:
    - Rhomboids
    - Latissimus dorsi
    - Biceps
    - Dumbbell exercises for supraspinatus and deltoid
    - Continue serratus anterior strengthening exercises push-ups floor
  - Continue trunk/LE strengthening exercises
  - Continue neuromuscular exercises
  - Continue self-capsular stretches

- Week 17-20
  - Continue all exercises above
  - Emphasis on gradual return to recreational activities

☐ **Phase IV (Months 20-28)**

- Return to Activity
- Goals:
  - Progressively increase activities to prepare patient for full functional return
- Criteria to Progress to Phase IV:
  - Full ROM
  - No pain or tenderness
  - Satisfactory clinical exam
- Exercise
  - Initiate interval sports programs (if patient is a recreational athlete)
  - Continue tubing exercises listed in Phase III
  - Continue all strengthening exercises
  - Continue ROM exercises

Comments:

Frequency: _____ times per week **Duration: _____ weeks**

Signature: _____ **Date: _____**

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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

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

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 1st, 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

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