Name:

DOB:

Date:

NYU Medical Center
NYUHJD Orthopaedic Surgery

Laith Jazrawi, MD
333 E 38th St, New York, NY 10016
Phone: (646) 501-7223 Fax: (646) 754-9505
www.NewYorkOrtho.com

PHYSICAL THERAPY/OCCUPATIONAL THERAPY REFERRAL
SHOULDER

PATIENT: _____

DIAGNOSIS: _____ **Right** _____ **Left** _____ **Bilateral**

_____ AC Joint Arthritis
_____ Acromioclavicular Separation
_____ Anterior Instability
_____ Frozen Shoulder
_____ Glenohumeral Arthritis
_____ Impingement Syndrome
_____ Multidirectional Instability
_____ Osteonecrosis Humeral Head
_____ Posterior Instability
_____ Proximal Humerus Fracture
_____ Rotator Cuff Tear
_____ Other _____

SURGERY DATE: _____ **Right:**_____ **Left:**_____ **Bilateral:**_____

_____ Acromioplasty/RC Repair (arthroscopic/open)
_____ Anterior Shoulder Repair (arthroscopic/open)
_____ Arthroscopic Subacromial Decompression
_____ Inferior Capsular Shift
_____ Lateral Clavicle Resection
_____ ORIF Proximal Humerus Fracture
_____ Other _____
_____ Posterior Shoulder Repair
_____ Proximal Humeral Replacement
_____ Proximal Humeral Replacement and Tuberosity Reattachment
_____ Shoulder Arthroscopy
_____ Total Shoulder Replacement

RX:

_____ Local Modalities _____ Ultrasound _____ Heat _____ Cold

ROM Exercises: (____forward elevation, ____external rotation, ____internal rotation to chest, ____behind back)

_____ PROM: Limitations:_____
_____ AAROM _____ AROM _____ Gentle Stretching to increase ROM

STRENGTHENING: _____ deltoid _____ external _____ internal rotation _____ scapular muscles
_____ isometrics _____ Isotonic (Progressive Theraband) _____ Isokinetic

Additional Instructions/Precautions: _____

Frequency/duration of Treatment:_____**times per week for** _____**weeks**

Signature _____ **Date:** _____