

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

Shoulder Arthroscopy and Rotator Cuff Repair +/-Biceps Tenodesis

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 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. Alternatively, Cryocuff or Game-ready ice cuff can be used as per instructions.

You will be contacted by Gotham surgical brace company 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 and Second Post-Operative Day

- A. Continue Icing.
- B. Pain medications as needed

Third Post-Operative Day

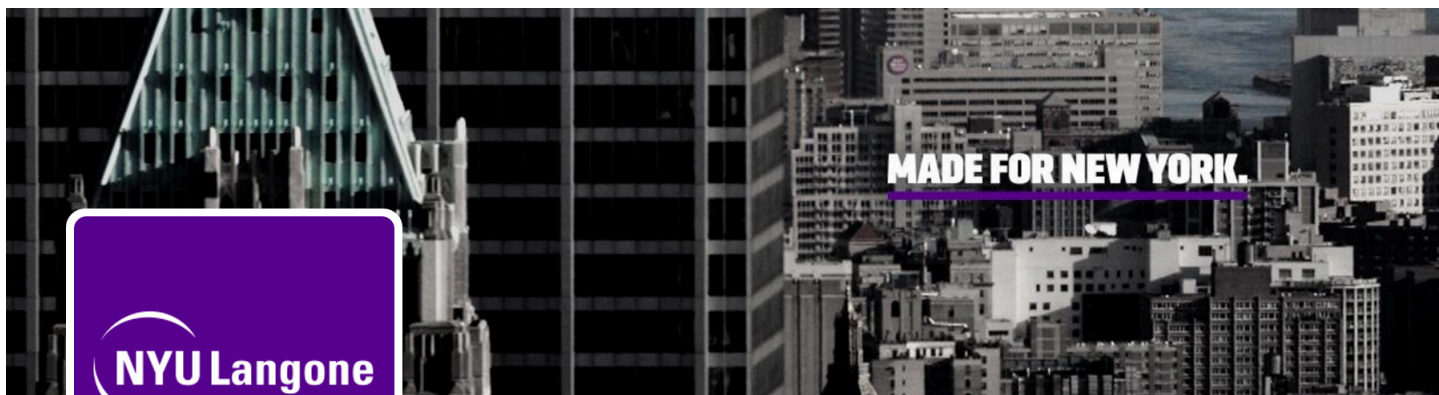
- A. You may remove surgical bandage and shower this evening. Apply regular bandages to these wounds prior to showering and when showering is complete apply fresh regular bandages. You will need to follow this routine for 2 weeks after surgery.

Physical Therapy

- A. Physical Therapy should begin at 4 weeks. Please call your preferred facility to make an appointment.

**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.



Dr. Laith M. Jazrawi

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

Rehabilitation Protocol After Arthroscopic Rotator Cuff Repair

The anatomic configuration of the shoulder joint (glenohumeral joint) is often compared to that of 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. This configuration provides less bony stability than a true ball and socket joint, like the hip. The stability and movement of the shoulder is controlled primarily by the rotator cuff muscles, with assistance from the ligaments, glenoid labrum and capsule of the shoulder. The rotator cuff is a group of four muscles: subscapularis, supraspinatus, infraspinatus and teres minor (Figure 1).

Rotator cuff tears can occur from repeated stress or from trauma. Throwing a baseball can create up to 750 newtons of distractive force on the shoulder². This places a significant amount of stress on the rotator cuff while trying to dissipate this force. This stress and force may be even greater if there is improper form or mechanics while throwing. This repeated stress may lead to rotator cuff tears. Rotator cuff trauma also may result from falling on your arm, bracing your arm in an accident, arm tackling in football or any large sudden force applied to the arm. Most rotator cuff tears involve the supraspinatus and/or the infraspinatus. Occasionally isolated tears of the subscapularis can occur. This usually results from trauma rotating the shoulder outward.

The rotator cuff tendons also undergo some degeneration with age. This process alone can lead to rotator cuff tears in older patients. Patients over 50 years of age are more susceptible to sustaining a significant rotator cuff tear from trauma³.

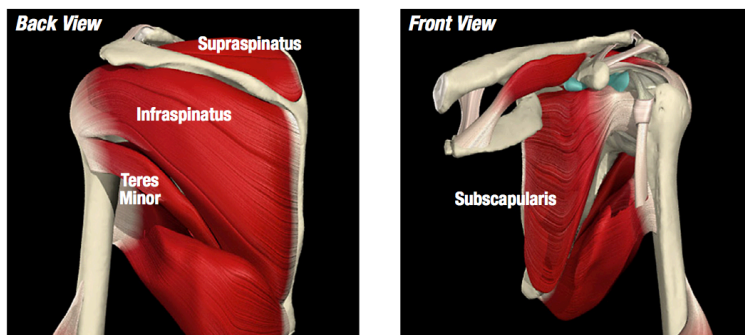


Figure 1 Rotator cuff anatomy

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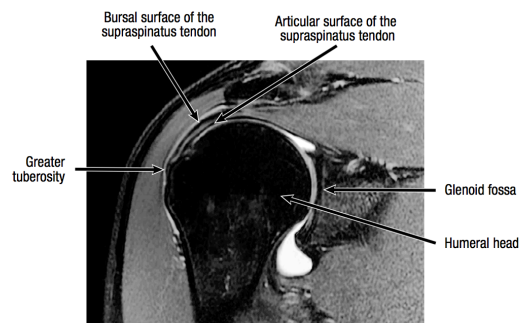


Figure 2. Coronal MRI Image of the Supraspinatus Note the black line of the bursal surface and articular surface. In this normal shoulder this tendon continues all the way to the greater tuberosity, the attachment site on the humerus. When there is a rotator cuff tear these black lines will become disrupted before reaching the greater tuberosity.

Rehabilitation Protocol After Arthroscopic Rotator Cuff Repair

Rotator cuff tears can be classified in various ways. The first classification is a partial thickness or a full thickness tear. Normal tendon thickness is 9 to 12 mm. Partial thickness tears start on one surface of the tendon, but do not progress through the depth of the tendon. These can be bursal surface tears or articular sided tears. Figure 2 shows the normal anatomy of the bursal and articular side of the rotator cuff. Bursal surface tears occur on the outer surface of the tendon and may be caused by repetitive impingement. Articular sided tears (Figure 3) occur on the inner surface of the tendon, and are most often caused by internal impingement or tensile stresses related to overhead sports. Full thickness or complete tears (Figure 4) extend from one surface of the tendon all the way through to the other surface of the tendon. Full thickness tears are often caused by trauma, such as falling on the arm. Since a portion of the tendon is completely disrupted, there also will be some tendon retraction. Retraction is movement of the tendon away from its insertion point back toward the muscle.⁴ After determining the type of tear, a classification system is used to assess the size of the tear. Type I tears are tears less than 2 cm in width and Type II tears are greater than 2 cm.

Surgical repair of a rotator cuff tear can be done arthroscopically or with a mini- open procedure. A 2007 review published in The Journal of Bone and Joint Surgery stated that equally successful outcomes can be attained from either technique⁵. The primary goal of a rotator cuff repair is to restore the normal anatomy by approximating the rotator cuff tendon back to its normal attachment site on the greater tuberosity of the humerus. This is done by passing sutures through the tendon and then tying the tendon down to suture anchors that have been placed in the humerus. Prior to bringing the tendon back to its insertion, the edges of the tear may need to be brought together, referred to as side-to-side repair or convergence (Figure 5). Not all rotator cuff tears are repairable. A tear may be un-repairable if the tear is too large, there is too much retraction, or the tissue quality is too poor. The degree of success for tears that are repaired is related to various factors, including tear size, the number of tendons involved, patient age, associated injuries and post operative rehabilitation ^{6, 7}.

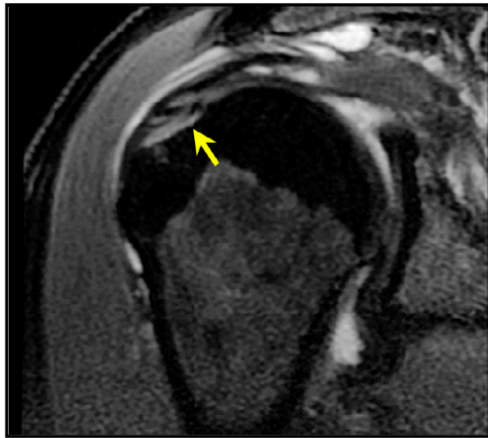


Figure 3 Coronal MRI image of an articular surface tear of the supraspinatus. Note the top black line has maintained continuity but the undersurface black line is disrupted.

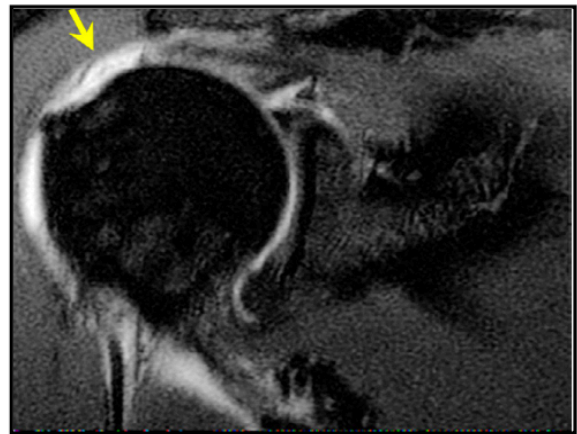


Figure 4 Coronal MRI image of a full thickness tear of the supraspinatus. Note the white fluid present where the dark tendon should be.

Rehabilitation Protocol After Arthroscopic Rotator Cuff Repair

Rehabilitation is vital to regaining motion, strength and function of the shoulder after surgery. Initially patients will use a sling to protect the repair site and allow healing of the tendon back to the bone. During this time, passive motion exercises are started to prevent the shoulder from getting stiff and losing mobility. The rehabilitation program will gradually progress to more strengthening and control type exercises. The rehabilitation guidelines will vary depending on the size of the tear and quality of the tendon. The rehabilitation guidelines for Type I and Type II tears of the supraspinatus or infraspinatus and isolated subscapularis tears are presented below 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, rehabilitation compliance and injury severity.

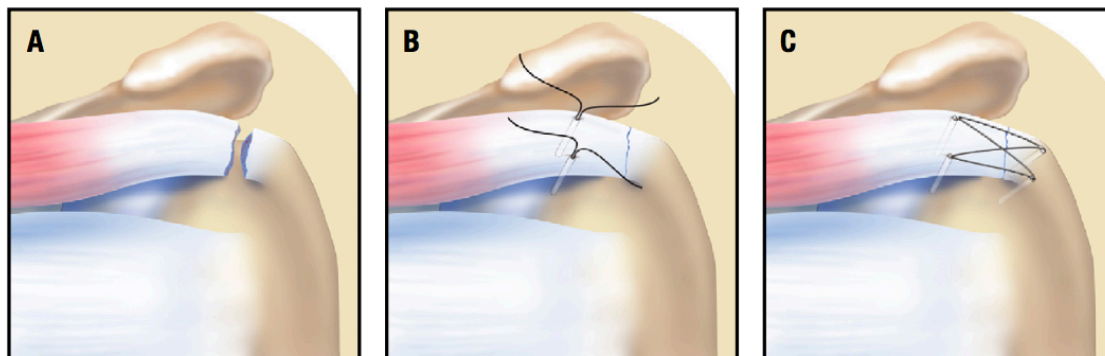


Figure 5 Rotator cuff repair technique using anchors and sutures. The tear (A) is approximated. Then suture anchors are placed on both sides of the tear (B and C). Finally the tendon is approximated back to the bone with various suture patterns to decrease focal stress.

Rehabilitation Protocol After Arthroscopic Rotator Cuff Repair

Phase I (Surgery to 4 weeks after surgery)

Precautions	<ul style="list-style-type: none"> ○ Sling immobilization with supporting abduction pillow to be worn at all times except for showering and rehab under guidance of PT (if instructed to start before 4 weeks post surgery)
Range of Motion	<ul style="list-style-type: none"> ○ True Passive Range of Motion Only to Patient Tolerance ○ Goals: 140° Forward Flexion, 40° External Rotation with elbow at side, 60-80° Abduction without rotation, Limit Internal Rotation to 40° with the shoulder in the 60-80° abducted position ○ Maintain elbow at or anterior to mid-axillary line when patient is supine
Therapeutic Exercises	<ul style="list-style-type: none"> ○ No canes or pulleys during this phase ○ Codman exercises/ pendulums ○ Elbow/wrist/hand range of motion and grip strengthening
Other Suggestions	<ul style="list-style-type: none"> ○ Heat/Ice before and after PT sessions

Phase II (4 weeks to 8 weeks following surgery)

Precautions	<ul style="list-style-type: none"> ○ D/C sling immobilization
ROM	<ul style="list-style-type: none"> ○ 4-6 weeks: Gentle passive stretch to reach ROM goals from Phase I ○ 6-8 week: Begin AAROM -> AROM as tolerated
Range of Motion Exercises	<ul style="list-style-type: none"> ○ Increase Forward Flexion, Internal/External Rotation to full motion as tolerated
Therapeutic Exercises	<ul style="list-style-type: none"> ○ 4-6 weeks: Begin gentle AAROM exercises (supine position), gentle joint mobilizations (grades I and II), continue with Phase I exercises ○ 6-8 weeks: Progress to active exercises with resistance, shoulder flexion with trunk flexed to 45° in upright position, begin deltoid and biceps strengthening
Other Suggestions	<ul style="list-style-type: none"> ○ Modalities per PT discretion

Rehabilitation Protocol After Arthroscopic Rotator Cuff Repair

Phase III (8 weeks to 12 weeks following surgery)

ROM	○ Progress to full AROM without discomfort
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Continue with scapular strengthening ○ Continue and progress with Phase II exercises ○ Begin internal/external rotation isometrics ○ Stretch posterior capsule when arm is warmed-up
Other Suggestions	○ Modalities per PT discretion

Phase IV (3 months to 6 months following surgery)

ROM	○ Full range of motion without discomfort
Therapeutic Exercises	<ul style="list-style-type: none"> ○ Advance strengthening as tolerated: isometrics -> therabands-> light weights (1- 5 lbs) ○ 8-12 repetitions/2-3 sets for rotator cuff, deltoid and scapular stabilizers ○ Return to sports at 6 months if approved
Other Suggestions	○ Modalities per PT discretion

***If biceps tenodesis was performed – no biceps strengthening until 8 weeks post-op

References

1. Wilk KE, Reinold MM, Dugas JR, Arrigo CA, Moser MW, Andrews JR. Current concepts in the recognition and treatment of superior labral (SLAP) lesions. *J Orthop Sports Phys Ther.* May 2005;35(5):273-291.
2. Burkhart SS, Morgan CD, Kibler WB. Shoulder injuries in overhead athletes. The "dead arm" revisited. *Clin Sports Med.* Jan 2000;19(1):125-158.
3. Wolf BR, Dunn WR, Wright RW. Indications for repair of full-thickness rotator cuff tears. *Am J Sports Med.* Jun 2007;35(6):1007-1016.
4. Kuhn JE, Dunn WR, Ma B, et al. Interobserver agreement in the classification of rotator cuff tears. *Am J Sports Med.* Mar 2007;35(3):437-441.
5. Nho SJ, Shindle MK, Sherman SL, Freedman KB, Lyman S, MacGillivray JD. Systematic review of arthroscopic rotator cuff repair and mini-open rotator cuff repair. *J Bone Joint Surg Am.* Oct 2007;89 Suppl 3:127-136.
6. Abrams JS. Arthroscopic approach to massive rotator cuff tears. *Instr Course Lect.* 2006;55:59-66.
7. Boes MT, McCann PD, Dines DM. Diagnosis and management of massive rotator cuff tears: the surgeon's dilemma. *Instr Course Lect.* 2006;55:45-57.



Rehabilitation Protocol: Arthroscopic Rotator Cuff Repair

Name: _____

Date: _____

Diagnosis: _____

Date of Surgery: _____



Phase I (Weeks 0-4)

- Sling immobilization with supporting abduction pillow to be worn at all times except for showering and rehab under guidance of PT (if instructed to start before 4 weeks post surgery)

If physician wants therapy to start before 4 weeks post op:

- Range of Motion – True Passive Range of Motion Only to Patient Tolerance
 - Goals: 140° Forward Flexion, 40° External Rotation with elbow at side, 60-80° Abduction without rotation, Limit Internal Rotation to 40° with the shoulder in the 60-80° abducted position
 - Maintain elbow at or anterior to mid-axillary line when patient is supine
- Therapeutic Exercise – No canes or pulleys during this phase
 - Codman Exercises/Pendulums
 - Elbow/Wrist/Hand Range of Motion and Grip Strengthening
 - Isometric Scapular Stabilization
- Heat/Ice before and after PT sessions



Phase II (Weeks 4-8)

- Discontinue sling immobilization
- Range of Motion
 - **4-6 weeks:** Gentle passive stretch to reach ROM goals from Phase I
 - **6-8 weeks:** Begin AAROM → AROM as tolerated
- Therapeutic Exercise
 - **4-6 weeks:** Being gentle AAROM exercises (supine position), gentle joint mobilizations (grades I and II), continue with Phase I exercises
 - **6-8 weeks:** Progress to active exercises with resistance, shoulder flexion with trunk flexed to 45° in upright position, begin deltoid and biceps strengthening**
- Modalities per PT discretion



Phase III (Weeks 8-12)

- Range of Motion – Progress to full AROM without discomfort
- Therapeutic Exercise
 - Continue with scapular strengthening
 - Continue and progress with Phase II exercises
 - Begin Internal/External Rotation Isometrics
 - Stretch posterior capsule when arm is warmed-up
- Modalities per PT discretion



Hospital for Joint Diseases

NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, M.D.

Chief, Division of Sports Medicine

Associate Professor of Orthopaedic Surgery

Tel: (646) 501-7223 option 4, option 2

Fax: (646) 501-7234

Web: newyorkortho.com

orthosurgery.med.nyu.edu/sports-medicine



Phase IV (Months 3-6)

- Range of Motion – Full without discomfort
- Therapeutic Exercise – Advance strengthening as tolerated: isometrics → therabands → light weights (1-5 lbs),
 - 8-12 repetitions/2-3 sets for Rotator Cuff, Deltoid and Scapular Stabilizers
 - Return to sports at 6 months if approved
- Modalities per PT discretion

Comments:

****IF BICEPS TENODESIS WAS PERFORMED - NO BICEPS STRENGTHENING UNTIL 8 WEEKS POST-OP**

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