



Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

MEDIAL / LATERAL EPICONDYLITIS (NON-OP)

NON-OP PHYSICAL THERAPY PROTOCOL

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Patient Name:	Date:
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<u>X</u> Evaluate and Treat <u>X</u> Provide patient with home program

Frequency: <u>2-3</u> x/week x <u>6</u> weeks

Modalities:

- \underline{X} Phonophoresis with 0.05% Fluocinonide
- \underline{X} Iontophoresis with 4mg/ml Dexamethasone
- <u>X</u> Ultrasound



<u>X</u> Dry Needling*

 \underline{X} Electrical Stimulation

Exercises:

<u>X</u> Medial / Lateral Epicondylitis Program

Special Instructions:

Isometric and eccentric forearm & wrist strengthening

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient $_$ would $_X_$ would not benefit from social services.

Date:_____

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