



Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

SCAPULAR DYSKINESIA (NON-OP)

NON-OP PHYSICAL THERAPY PROTOCOL

Bryan M. Saltzman, M.D.

Indiana University Health Physicians Assistant Professor of Orthopaedic Surgery, Indiana University Sports Medicine, Cartilage Restoration, Shoulder/Elbow IU Health Methodist Hospital – 1801 N Senate Ave, Indianapolis, IN 46202 IU Health North – 201 Pennsylvania Pkwy #100, Carmel, IN 46280 317-944-9400

www.bryansaltzmanmd.com

Patient Name: Date:

X Evaluate and Treat **X** 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



- \underline{X} Dry Needling*
- \underline{X} Electrical Stimulation

Exercises:

- <u>X</u> Cervical Stabilization Program
- <u>X</u> Shoulder Impingement Exercise
- \underline{X} Shoulder Gentle Hands on Passive ROM
- <u>X</u> Scapular Stabilization Program

Special Instructions:

Peri-scapular Stabilization and Strengthening

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient <u>would X</u> would not benefit from social services.

Date:_____

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