



# Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

## **SCAPULAR DYSKINESIA (NON-OP)**

### NON-OP PHYSICAL THERAPY PROTOCOL

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Patient Name: Date:
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**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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