



GLENOID OPEN REDUCTION INTERNAL FIXATION (ORIF)

PHYSICAL THERAPY PROTOCOL

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Patient Name: _____ **Date of Surgery:** _____

___ Evaluate and Treat

___ Provide patient with home program

Frequency: _____x/week x _____weeks

	RANGE OF MOTION	IMMOBILIZER	EXERCISES
PHASE I 0-6 weeks	Limit ER to passive 45° to protect subscap repair FE progress as tolerated	0-2 weeks: Worn at all times (day and night) Off for gentle exercise only 2-6 weeks: Worn daytime only	0-3 weeks: Grip strengthening, pendulum exercises Elbow/wrist/hand ROM at home 3-6 weeks: Begin cuff, deltoid isometrics; limit ER to passive 45° No active IR nor extension until 6 weeks
PHASE II 6-12	Increase as tolerated to full Begin active assisted/active	None	6-8 weeks: Begin light resisted ER, forward flexion and abduction



weeks	internal rotation and extension as tolerated after 6 weeks		8-12 weeks: Begin resisted internal rotation, extension and scapular retraction
PHASE III 12-24 weeks	Progress to full motion without discomfort	None	Advance strengthening as tolerated Closed chain scapular rehab and functional rotator cuff strengthening; focus on anterior deltoid and teres Maximize subscapular stabilization

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

Date: _____

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