LATARJET / DISTAL TIBIAL ALLOGRAFT (DTA)

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 weeks	Increase as tolerated to full Begin active assisted/active internal rotation and extension as tolerated after 6	None	**6-8 weeks**: Begin light resisted ER, forward flexion and abduction **8-12 weeks**: Begin resisted internal rotation, extension and scapular

	weeks		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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