Rehabilitation Protocol: Arthroscopic Posterior Shoulder Stabilization

Name: _______________________________ Date: ___________________________

Diagnosis: _______________________________________________________ Date of Surgery: ______________________

□ Phase I (Weeks 0-6)
   - Sling immobilization at all times (in flexion, abduction and 0° of rotation) except for showering and rehab under guidance of PT
   - Range of Motion – None for Weeks 0-3
     - Weeks 3-6: Begin passive ROM - Restrict motion to 90° of Forward Flexion, 90° of Abduction, and 45° of Internal Rotation
   - Therapeutic Exercise
     - Elbow/Wrist/Hand Range of Motion
     - Grip Strengthening
     - Starting Week 3: Begin passive ROM activities: Codman’s, Anterior Capsule Mobilization
   - Heat/Ice before and after PT sessions

□ Phase II (Weeks 6-12)
   - Sling immobilization for comfort only
   - Range of Motion – Begin AAROM/AROM
     - Goals: 135° of Forward Flexion, 120° of Abduction, Full External Rotation
   - Therapeutic Exercise
     - Continue with Phase I exercises
     - Begin active-assisted exercises – Deltoid/Rotator Cuff Isometrics
     - Starting Week 8: Begin resistive exercises for Rotator Cuff/Scapular Stabilizers/Biceps and Triceps (keep all strengthening exercises below the horizontal plane during this phase – utilize exercise arcs that protect the posterior capsule from stress)
   - Modalities per PT discretion

□ Phase III (Weeks 12-16)
   - Range of Motion – Progress to full AROM without discomfort
   - Therapeutic Exercise – Advance Phase II exercises
     - Emphasize Glenohumeral Stabilization, External Rotation and Latissimus eccentrics
     - Begin UE ergometer/endurance activities
   - Modalities per PT discretion

□ Phase IV (Months 4-6)
   - Range of Motion – Full without discomfort
   - Therapeutic Exercise – Continue with strengthening
     - Sport/Work specific rehabilitation – Plyometric and Throwing/Racquet Program
     - Continue with endurance activities
     - Return to sports at 6 months if approved
   - Modalities per PT discretion

Comments:

Frequency: ____ times per week Duration: _____ weeks

Signature: _______________________________ Date: ___________________________