



CONCORD ORTHOPAEDICS

PHYSICAL THERAPY REFERRAL

#1

LOCATION: _____

PHONE #: _____

PATIENT'S NAME: _____

DOB: _____

DIAGNOSIS: ROTATOR CUFF DYSFUNCTION R / L

TREATMENT:

1. RANGE OF MOTION
2. PAIN RELIEF
3. STRENGTHENING (ISOMETRICS → THERABAND → PRE'S)
4. SCAPULAR STABILIZATION
5. IONTOPHORESIS with Dexamethasone 0.4%
6. PHONOPHORESIS with Betamethasone 0.1%
7. AQUATIC THERAPY (IF NECESSARY)
8. DEVELOP HOME EXERCISE PROGRAM

FREQUENCY: 2 TIMES PER WEEK FOR 8 – 12 WEEKS

PRECAUTIONS / SPECIAL INSTRUCTIONS: _____

PHYSICIAN SIGNATURE: _____

DATE: _____

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