AC JOINT RECONSTRUCTION PHYSICAL THERAPY PROTOCOL

Name__________________________________________________ Date__________________

Diagnosis  s/p   RIGHT/LEFT AC Joint Reconstruction

Date of Surgery_________________________

Frequency: ____ times/week    Duration: _____ Weeks

______Weeks 1-6:
PROM 0-90 FF, 0-45 ABD MAX, ER/IR as tolerated
Elbow / wrist / hand ROM ok
NO cross body adduction for 8 weeks
Isometric exercises in all planes
NO RROM shoulder flexion until 12 weeks post-op

______Weeks 6-12:
Progressive full AAROM > AROM of the shoulder
Isotonic shoulder exercises
NO RROM shoulder flexion until 12 week post-op

Comments:

_____Functional Capacity Evaluation _____Work Hardening/Work Conditioning____ Teach HEP

Modalities
___Electric Stimulation   ___Ultrasound   ___ Iontophoresis   ___Phonophoresis   ___TENS
___ Heat before ___Ice after ___Trigger points massage
___ Other _____________________________            ____ Therapist’s discretion

Signature__________________________________________ Date__________________