ULNAR NERVE DECOMPRESSION WITH / WITHOUT TRANSPOSITION
Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

_____ **Evaluate and Treat** _____ **Provide patient with home exercise program**

Frequency: _____ x/week x _____ weeks

_____ **Phase I – Immediate Post-Operative Phase (Week 0-1).**

- **Goals**
  - Allow soft tissue healing of relocated nerve.
  - Decrease pain and inflammation.
  - Retard muscular atrophy.
- **Week1**
  - Posterior splint at 90° elbow flexion with wrist free for motion (sling for comfort).
  - Elbow compression dressing.
  - Exercises
    - Gripping.
    - Wrist ROM (passive only).
    - Shoulder isometrics (no shoulder ER).
  - Discontinue splint at 7-10 days.

_____ **Phase II – Intermediate Phase (Week 3-7).**

- **Goals**
  - Restore full pain free range of motion.
  - Improve strength, power, endurance of upper extremity musculature.
  - Gradually increase functional demands.
- **Week 3-5**
  - Progress elbow ROM, emphasize full extension.
  - Initiate flexibility exercises for:
    - Wrist ext/flexion.
    - Forearm supination/pronation.
    - Elbow ext/flexion.
  - Initiate strengthening exercises for:
    - Wrist ext/flexion.
    - Forearm supination/pronation.
    - Elbow ext/flexors.
    - Shoulder program (Thrower's Ten Shoulder Program).
- **Week 6-7**
  - Continue all exercises listed above.
  - Initiate light sport activities .

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_____ **Phase III – Advanced Strengthening Program (Week 8-12)**

- **Goals**
  - Improve strength/power/endurance.
  - Gradually initiate sporting activities.
- **Week 8-11**
  - Initiate eccentric exercise program.
  - Initiate plyometric exercise drills.
  - Continue shoulder and elbow strengthening and flexibility exercises.
  - Initiate interval throwing program for throwing athletes.

_____ **Phase IV – Return to Activity (Week 12-32)**

- **Goals**
  - Gradual return to activities.
- **Week 12**
  - Return to competitive throwing.
  - Continue Thrower's Ten Exercise Program.

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.

Physician Name: _____ Date: _____

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