PROXIMAL HUMERUS OPEN REDUCTION INTERNAL FIXATION (ORIF)
Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

Procedure: Right / Left Proximal Humerus ORIF

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: _____ x/week x _____ weeks

_____ **Phase I (0-1 week):** ***Initial wound healing, provisional fracture consolidation.***

- No formal PT.
- Wear sling at ***all*** times.
- Maintenance motion at home (Codman shoulder swings, elbow/wrist ROM in sling 2-3 times per day).

_____ **Phase II (1-6 weeks):** ***Protected PROM (no active motion)***

- Start formal PT.
- Sling at all times, except for hygiene/PT.
- Elbow and wrist ROM exercises out of the sling 3x/day
- Supervised PROM within the following limits (based on intra-op security of the repair):
  a. forward elevation in the scapular plane _____
  b. IR with arm at side _____
  c. ER with arm at side _____
  d. ***Avoid abduction in the coronal plane.***
- Gentle deltoid and periscapular isometric exercises ***(avoid isolated rotator cuff contraction until after 8 wks as this may compromise repair).***

_____ **Phase III (6-3 months):** ***Advance motion and gentle strengthening.***

- Discontinue sling if fracture healing adequate.
- Light passive stretching at end ranges; begin active-assisted ROM and gradually progress beyond above ROM limits. After 8 weeks, may progress to AROM as tolerated.
- Advance deltoid and periscapular isometric strengthening.
  After 8 weeks, may begin light cuff isometrics with arm at side.

The Christ Hospital™ Physicians
Joint & Spine

_____ **Phase IV (3-6 months):** ***Achieve terminal motion and more aggressive strengthening.***

- Terminal passive stretching at end ranges (especially posterior capsule); progress A+AAROM in all planes.
- **Advance as tolerated from isometrics → bands → light weights (1-5 lbs)** w/8-12 reps x 2-3 sets for cuff, deltoid, scapular stabilizers *(Only do this **3x/week** to avoid cuff tendonitis)*.
- @ 4.5 months, begin eccentrically resisted motions, plyometrics *(weighted ball toss)*, proprioception *(body blade)* and then progress as tolerated into sports-related rehab and advanced conditioning.

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: _____

The Christ Hospital™ Physicians
Joint & Spine