



# MEDIAL / LATERAL EPICONDYLITIS (NON-OP) NON-OP PHYSICAL THERAPY PROTOCOL

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Evaluate and Treat      \_\_\_\_\_ Provide patient with home program

Frequency: \_\_\_\_\_ x/week x \_\_\_\_\_ weeks

### Modalities:

- \_\_\_\_\_ Phonophoresis with 0.05% Fluocinonide
- \_\_\_\_\_ Iontophoresis with 4mg/ml Dexamethasone
- \_\_\_\_\_ Ultrasound
- \_\_\_\_\_ Electrical Stimulation

### Exercises:

- \_\_\_\_\_ Medial / Lateral Epicondylitis Program

### Special Instructions:

Isometric and eccentric forearm & wrist strengthening

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: \_\_\_\_\_