

Physical Therapy Prescription – Medial Epicondylitis Rehab Protocol

Name: _____

Date: _____

Procedure: R / L

Date of Surgery: _____

Frequency: 2-3 times per week for _____ weeks

PHASE I (Weeks 0 – 6): decrease edema

- **Brace:** On all times except for hygiene. Non weight bearing
- **Range of Motion:** Passive ROM as tolerated
- **Therapeutic Exercises:** Gentle hand/wrist/elbow/shoulder stretching, isometric hand/wrist/elbow/shoulder strengthening - avoid wrist flexion.
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase II (Weeks 6 – 8)

- **Brace:** Discontinue. 5 lb weight bearing
- **Range of Motion:** Full range of motion. Begin active wrist extension.
- **Therapeutic Exercises:** Advance strengthening exercises in phase I to resistive, maintain flexibility/ROM, begin gentle active wrist flexion exercises.
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase III (Weeks 8 – 12)

- **Weightbearing:** As tolerated
- **Brace:** None
- **Range of Motion:** Full
- **Therapeutic Exercises:** Advance phase II activities, gradual progression toward return to full activity.
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature: _____

Date: _____