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Physical Therapy Prescription – Ulnar Nerve Transposition Rehab Protocol

Name: _____

Date: _____

Procedure: R / L

Date of Surgery: _____

Frequency: 2-3 times per week for _____ weeks

PHASE I (Weeks 2 – 6): decrease edema

- **Range of Motion:** Full pain free ROM. Emphasize full extension.
- **Therapeutic Exercises:** Gentle hand/wrist/elbow/shoulder stretching, isometric hand/wrist/elbow/shoulder strengthening
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase II (Weeks 6 – 8)

- **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 extension exercises. Gradually initiate sporting activities.
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Phase III (Weeks 8 – 12)

- **Range of Motion:** Full
- **Therapeutic Exercises:** Advance phase II activities, gradual progression toward return to full activity. Initiate eccentric exercise program. Initiate plyometric exercise drills. Continue shoulder and elbow strengthening and flexibility exercises. Initiate interval throwing program for throwing athletes.
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

Signature: _____

Date: _____