THE CENTERS OF EXCELLENCE
ORTHO MONTANA

UPPER EXTREMITY RETURN TO SPORT ASSESSMENT

To be completed prior to Return to Sport clearance by the physician and faxed back to Ortho Montana at 406-794-3297

Name: _____DOB: _____ Date: _____

DOS:_____ R or L Physician:_____ Therapist:_____

Test		R	L	%	Goals
Shoulder Dynamometer ER + IR **At 0 degree Abduction** **&** **At 90 degrees Abduction**	0 Abduction IR	lbs	lbs	_____% **Pass / Fail**	≥90%
	0 Abduction ER	lbs	lbs	_____% **Pass / Fail**	≥90%
	90/90 IR	lbs	lbs	_____% **Pass / Fail**	≥90%
	90/90 ER	lbs	lbs	_____% **Pass / Fail**	≥90%
Closed Kinetic Chain Upper Extremity Stability Test Average of 3 Trials; 15 seconds each		Taps / Taps / Taps		_____ **taps** **Pass / Fail**	≥ 21
Shot Put Throw (6 lbs) Best of 3 trials		in	in	_____% **Pass / Fail**	≥90%
Endurance Test (5% Body Weight DB) **Side lying**		Reps/60s	Reps/60s	_____% **Pass / Fail**	≥90%
Endurance Test (5% Body Weight DB) **Prone**		Reps/60s	Reps/60s	_____% **Pass / Fail**	≥90%

* If a patient fails 1 test, address deficit with specific HEP. Patient will perform for 4-6 weeks and then RTS.

** If a patient fails 2 or more tests, 4-6 weeks of formal physical therapy to address deficits and then re-test.