Mary Free Bed
Rehabilitation Hospital

Motion Analysis Center
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Motion Analysis Center Referral Form

Patient Selection Guidelines for Gait Analysis

- ~2 yrs independent walking (w/device if needed)
- Age 4 or older
- Repeatable gait pattern
- Ability to walk 20ft multiple times without hands on assistance
- Ability to follow instructions and cooperate with 2-4 hour test
- Tolerant of tactile stimuli

Patient Information

Patient Name:_____DOB:___/___/___SSN#_____

Parent/Guardian Name:_____

Address:_____City:_____State:_____Zip:_____

Phone: (____)_____Alternate Phone: (____)_____

Information to Provide

- Past surgical history and recent clinical dictation
- Insurance Information
- Date of next appointment:___/___/___

Diagnosis

❒ Cerebral Palsy / GMFCS Level: ❒ I ❒ II ❒ III ❒ IV
❒ Traumatic Brain Injury
❒ Spina bifida / ❒ High-lumbar ❒ Mid-lumbar ❒ Low-lumbar/sacral
❒ Stroke
❒ Other: _____

Distribution:
❒ Hemiplegia (side___)
❒ Diplegia
❒ Triplegia
❒ Quadriplegia

Dynamic EMG

Standard surface: bilateral medial hamstrings, rectus femoris, vastus lateralis, medial gastrocnemius and tibialis anterior.

❒ Additional muscles by surface EMG (specify):_____

❒ Additional muscles by fine wire EMG (specify):_____

Goal of Evaluation

Please check all that apply.

❒ Treatment planning
❒ Treatment outcome assessment (Prior baseline gait analysis required)
❒ Orthotic recommendation/assessment
❒ See Notes
❒ Other: _____

_____

_____

Physician Signature

Physician Signature: _____Date Signed:___/___/___

Print Name: _____