Mary Free Bed® Rehabilitation

Referral Form

MOTION ANALYSIS LAB

301 Michigan St. NE #215, Grand Rapids, MI 49503
P: 616.840.8682 F: 616.840.9763

PATIENT SELECTION GUIDELINES FOR GAIT ANALYSIS

- Well established, consistent gait pattern
- Age 4 or older developmentally
- Ability to repeatedly walk 20 feet without assistance
- Ability to follow simple instructions
- Ability to cooperate with 2 - 4 hour test
- Tolerant of handling and equipment

PATIENT INFORMATION

_____ _____
Name *Date of Birth*

_____ _____
Parent/Guardian Name: (where applicable)

_____ _____ _____ _____
Address *City* *State* *ZIP*

_____ _____
Phone *Alternate Phone*

Gender Identity: ❒ Female ❒ Male ❒ Non-binary ❒ Transgender Female ❒ Transgender Male ❒ Other

DIAGNOSIS

❒ Cerebral palsy (GMFCS Level: ❒I ❒II ❒III ❒IV)
❒ Traumatic brain injury
❒ Stroke
❒ Spina bifida
❒ Other_____

Distribution:
❒ Hemiplegia (side____)
❒ Diplegia
❒ Triplegia (side_____)
❒ Quadriplegia

Continued on back

EVALUATION TYPE

❒ **Full Study** (split screen video, physical therapy exam, kinematics, kinetics, plantar pressure, interpretation and recommendations)

Limited Study (Please check desired assessment(s)):

❒ Plantar pressure measurement

❒ Speed, cadence, step length measurement

❒ Ground reaction force (GRF) overlay on video

❒ Weight bearing assessment

❒ Shoe lift (leg length discrepancy) assessment

❒ Foot progression assessment

❒ Other _____

❒ EMG (Please list muscles requiring study and check side.)

_____ ❒Bilat ❒L ❒R

_____ ❒Bilat ❒L ❒R

_____ ❒Bilat ❒L ❒R

_____ ❒Bilat ❒L ❒R

_____ ❒Bilat ❒L ❒R

_____ ❒Bilat ❒L ❒R

NOTE: Rectus femoris and tibialis posterior fine wire insertion

GOAL OF EVALUATION (Please check all that apply.)

❒ Treatment planning

❒ Treatment outcome assessment (pre-treatment gait analysis required)

❒ Orthotic/prosthetic:

- ❒ Assessment
- ❒ In-study adjustment/tuning (requires adjustable componentry)

❒ Other:

_____

_____

_____

❒ Specific clinical question(s):

_____

_____

_____

PROVIDER INFORMATION

_____

Follow-up date with referring physician:

_____ _____

Physician Name (print) *Signature*

_____ _____ _____

Phone *Fax* *Date*