Motion & Gait Analysis Lab
1600 7th Ave South
PT & OT –McWane Bldg., 3rd floor
Birmingham, AL 35233
Phone: (205) 638-2230 Fax: (205) 638-6740

Gait & Motion Analysis Lab Referral Form

Guidelines for Participation in Motion and Gait Analysis

- Age 4 or older
- Tolerant of tactile stimuli
- Independent walking (with device if needed)***
- Ability to walk 20ft. multiple times***
- Ability to follow directions and cooperate with 2-4 hour test***

All criteria must be met for a comprehensive motion and gait analysis.

*** For those participating for the purpose of an orthotic evaluation only starred criteria are required.***

Patient Information

Female or Male (please circle one)
Patient Name:______________________________ DOB:______________MR #:______________
Diagnosis:______________________________
Parent/Guardian:______________________________
Address:______________________________
Phone:______________________________ Alternate Phone:______________________________
Patient/Guardian preferred language:______________________ Interpreter required: yes or no (please circle)

Required Documentation

Please provide the following documentation:

- Copy of Insurance Card and/or Medicaid Referral
- Relevant Clinic Notes
- Past Surgical History
- Date of next appointment and/or procedure

***Please note incomplete referrals will result in a delay in scheduling.

Gait Analysis

Reason For Referral/Physician's Goals for Evaluation:______________________________
Proposed Surgery/Treatment:______________________________
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☐ **Basic** 2D Gait Analysis
2D video analysis of gait, with interpretation

☐ **Orthotic Analysis**
(Ideal for orthotic evaluations)

Clinical exam, 2D video analysis of gait with real time ground reaction force vectors

☐ **Comprehensive** 3D Gait Analysis
(Ideal for consideration of pharmacological and/or surgical interventions)

Clinical exam, Video, Kinematics, Kinetics, & Surface EMG (up to 8 channels)

☐ **Standard EMG**: Bilateral Medial HS, Rectus, Gastrocnemius, and Tibialis Anterior

☐ Other EMG (please specify)______________
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Referral Source

Referring Physician:______________________________
Fax:______________________________ Phone:______________________________
Address (to receive final report):______________________________

______________________________ Physician Signature

______________________________ Date