

GAIT ANALYSIS REFERRAL FORM

NAME:
DOB:
ADDRESS:

POST CODE:
TEL NO:
HOSPITAL NO:

REFERRER DETAILS:
NAME:
ADDRESS:

POST CODE:
TEL NO:

DIAGNOSIS/ES:

- 1.
- 2.
- 3.
- 4.

GENERAL PRACTITIONER:
NAME:
ADDRESS:

POST CODE:

REASON FOR REFERRAL: Please ensure the referral question is clear, so that we can analyse appropriately.

CURRENT TREATMENT CONSIDERATIONS:

TYPE OF ANALYSIS REQUIRED:

| | |
|----------------------|--|
| Video | |
| Kinematics | |
| Kinetics | |
| EMG | |
| Pedobarograph | |
| Video vector | |
| Interpretation | |

ANY OTHER REQUESTS:

| | |
|---|---------------------------|
| Has the patient been for gait analysis in Derby before? | Yes / No / Unknown |
| If so, when? | |

| | | | |
|-----------------------------|--------------------------|--|--------------------------|
| WALKING ABILITY: | | BEHAVIOUR: | |
| Community independent | <input type="checkbox"/> | Appropriate for age | <input type="checkbox"/> |
| Household | <input type="checkbox"/> | Delay for age | <input type="checkbox"/> |
| Therapy only | <input type="checkbox"/> | Unable to follow commands from unfamiliar person | <input type="checkbox"/> |
| Walking aids: | | | |
| Orthoses: | | | |

RELEVANT MEDICAL HISTORY: (including surgeries etc)

MEDICATION:

OTHER CLINICIANS INVOLVED IN CARE: (Consultants, Physiotherapists ...)

| Name | Discipline | Site |
|------|------------|------|
| | | |

| | |
|----------------|--------------|
| Signed: | Date: |
| Designation: | |

Please send the completed form back to:

Mr S Attfield
 Head of Department / Clinical Scientist
 Derby Gait and Movement Laboratory
 London Road Community Hospital
 London Road
 Derby DE1 2QY

PLEASE ENSURE THAT ALL RELEVANT INFORMATION IS INCLUDED TO ALLOW US TO MAKE ACCURATE AND APPROPRIATE ANALYSIS AND RECOMMENDATIONS FOR YOUR PATIENT.