MOTION ANALYSIS LAB REFERRAL FORM

FAX form to 513-803-1111

Motion Analysis Lab
3430 Burnet Ave Suite 4.312
Cincinnati, Ohio 45229-3039

Please attach notes from most recent clinic visit.
Call 513-803-3192 with questions on completing this form.

PATIENT INFORMATION

Patient's Name: _____ Gender: _____ CCHMC MR#: _____

Weight: _____ kg Height: _____ cm Allergies: ☐ None ☐ Drug/Contract ☐ Food ☐ Product/Latex

GMFCS Level (if appropriate): _____ Specifics: _____

Date of Birth: _____ Parent/Guardian: _____

Home Phone: ( ) _____ Phone # (preferred): ( ) _____

REASON FOR APPROVAL

History / Symptoms / Potential diagnosis / Special needs:

List orthotics and/or assistive devices typically used:

SERVICES REQUESTED

☐		**Standard Gait Analysis** *Physical exam, kinematic and kinetic assessment, pedobarography, and EMG assessment, as described below.*
It is not necessary to complete this section if you have already indicated Standard Gait Analysis above.	☐	**Physical Exam**: Lower extremity range of motion and strength. *All services will require physical exam unless previously discussed with MAL staff. Call 513-803-3192 with questions.*
	☐	**Kinematics and Kinetics**: Lower extremity joint motion and loading. *Kinetic analysis may be limited by assistive device use.*
	☐	**Pedobarography**: Foot pressure patterns during walking.
	☐	**Electromyography**: Surface EMG measurement of muscle activity. *Standard muscles include bilateral rectus femoris, medial hamstrings, tibialis anterior, and gastrocnemius.*
☐		**Strength**: Biodex-based isokinetic testing at slow and fast speeds. Indicate joints in "Other" below.
☐		**Energy Cost**: Cosmed-based oxygen consumption while walking during 1-Min or 6-Min Walk Test.
☐		**Other:**

REQUESTING PRACTITIONER / GROUP

Physician Name _____

Contact Person _____ Telephone ( ) _____

Office Address _____ Fax ( ) _____

Print Name _____ Time: _____ Date: _____

Signature / Credentials of ordering Practitioner _____