

The Children's Hospital
Center for Gait and Movement Analysis (CGMA)
1056 East 19th Avenue, B476
Denver, CO 80218
Phone (303) 864-5805
Fax (303) 864-5815



CENTER FOR GAIT AND MOVEMENT ANALYSIS (CGMA) REFERRAL FORM

PATIENT'S NAME: _____ **DOB:** _____

MR #: _____ **Home #** _____ **Work#** _____

PARENT/GUARDIAN: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

***REFERRING PHYSICIAN:** _____

***PRIMARY CARE PHYSICIAN:** _____

*** DIAGNOSIS (ICD-9):** _____

Can he/she take at least 7-10 steps *independently* with or without an assistive device? _____

PERTINENT MEDICAL HISTORY (Please include all surgeries and dates):

SURGERIES:

Date	Side	Date	Side	Date	Side
___	___ adductor tenotomy	___	___ femoral osteotomy	___	___ clubfoot
___	___ iliopsoas tenotomy	___	___ tibial osteotomy	___	___ calcaneal osteotomy
___	___ varus derotation osteotomy	___	___ fibular osteotomy	___	___ triple arthrodesis
___	___ hamstring lengthening	___	___ post tib. split tendon trnsfr	___	___ botox _____
___	___ tendo-achilles lengthening	___	___ ant. tib split tendon trnsfr	___	___ phenol _____
___	___ Evans procedure	___	___ other _____		

CURRENT MEDICATIONS: _____

PRECAUTIONS: _____

PHYSICAL DEFORMITY:(PLEASE CHECK ALL THAT APPLY)

_____ Amputee B/R/L	_____ Equinovarus	_____ Stiff Knee Gait
_____ Club Foot	_____ Femoral Rotation	_____ Tibial Rotation
_____ Crouch Gait	_____ Intoeing	_____ Other _____
_____ Drop Foot	_____ Leg length difference > 2cm	

FUNCTIONAL PROBLEM(S):

_____ Anteversion >20 from age	_____ Scissoring	_____ Calcaneus/Excesive Dorsiflexion
_____ Circumducts	_____ Flexed Knee	_____ Drags Foot
_____ Hip Hikes	_____ Lacks Knee Extension	_____ Equinovarus/Toe Walker
_____ PelvicTilt> 30	_____ Recurvatum	_____ Intoe
_____ Psoas Tightness	_____ Valgus Knee	
_____ Recits Femoris Tightnes	_____ Varus Knee	_____ Other _____

REASON FOR REFERRAL (SPECIFIC QUESTIONS or SURGICAL CONSIDERATIONS, DATA INTERPRETATION, TREATMENT RECOMMENDATIONS?): _____

DATE OF PROPOSED PROCEDURE (IF APPLICABLE): _____

TYPE OF STUDY REQUESTED (Check one or more as needed):

- Motion Analysis (includes time-distance parameters, velocity and timing of gait events)
- Video only (included in other tests)
- Time-Distance Parameters only
- Ground Reaction Forces only
- N/A Foot Pressure Measurements (Will Be Available Soon)**
- Dynamic EMG (includes Ground Reaction Forces)
 - Routine Muscles (see below)
 - Specific (check off below)

SURFACE ELECTRODES

BOTH	R	L	MUSCLE	BOTH	R	L	MUSCLE
_____	_____	_____	*Tibialis Ant.	_____	_____	_____	*Gluteus max.
_____	_____	_____	*Gastrocnemius	_____	_____	_____	*Gluteus med.
_____	_____	_____	*Rectus femoris	_____	_____	_____	Adductors
_____	_____	_____	*Med. Hams	_____	_____	_____	Lat. Hams
_____	_____	_____	*Vastus Lateralis	_____	_____	_____	Other-please specify _____

INTRAMUSCULAR ELECTRODES (PLEASE LIMIT THE #)

_____	_____	_____	Tibialis post.	_____	_____	_____	Flex.dig long
_____	_____	_____	Peroneus long.	_____	_____	_____	Ext.dig.long
_____	_____	_____	Iliopsoas	_____	_____	_____	Rectus fem.

CONDITIONS FOR STUDY:

- barefoot shoes without brace shoes with brace
- assistive device barefoot assistive device with shoes and brace
- comparison between devices

ASSISTIVE DEVICES TO BE USED IN THE STUDY:

- none straight cane/s quad cane(s)
- walker reverse walker crutch(s) other

BRACE TO BE USED IN STUDY:

none Yes – type of brace _____

Does patient wear braces on a regular basis? (please circle):

- daily occasionally rarely never

***Referring Physician's Signature:** _____

***Referring Physician's Phone #** _____

***Primary Care Physician's Signature:** _____

Please send completed forms to:
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