Children's Hospital Colorado
Center for Gait and Movement Analysis (CGMA)
13123 East 16th Ave, B476
Aurora, CO 80045
Phone (720) 777-5805
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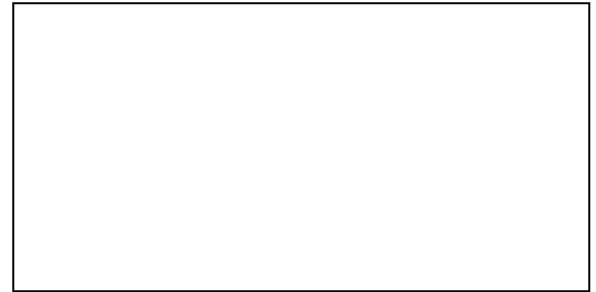

CENTER FOR GAIT AND MOVEMENT ANALYSIS (CGMA)
REFERRAL FORM

PATIENT'S NAME: ________________________________ **DOB:**___________________
MR #:____

PARENT/GUARDIAN:____

REFERRING PHYSICIAN: ____
PRIMARY CARE PHYSICIAN:____
DIAGNOSIS (ICD9):____
Can he/she take at least 7-10 steps *independently* with or without an assistive device? _____________

PRECAUTIONS:____

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

DATE OF SCHEDULED PROCEDURE (**IF APPLICABLE**):________________________________

TYPE OF STUDY REQUESTED (Check one or more as needed): (*Standard components with full analysis)

_____*Motion Analysis – Kinematics, kinetics, temporal distance information
_____*Video only (included in other tests)
_____*Temporal-Distance Parameters only
_____*Ground Reaction Forces only
_____*Foot/ Plantar Pressure Measurements
_____*Dynamic EMG (includes Ground Reaction Forces)
_____ Sports performance motion analysis
_____ Treadmill training
______Upper Extremity Evaluation
_____ Oxygen Consumption Testing
______Isokinetic testing

EMG - INTRAMUSCULAR ELECTRODES: Please specify which muscle/muscles/right/left_________

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

_____Treadmill training Other:_________________________
_____Isokinetic testing (please specify)

Referring Physician's Signature: ______________________________________

Referring Physician's Phone # ____

Primary Care Physician's Signature:____

Please send completed forms to above noted address