The Center For Motion Analysis

Phone: 860.837.9201 *Fax:* 860.837.9213

Connecticut Children's Patient Label
for internal use only

Referral Form

Date of Referral ______________________________

Patient's Name ______________________________

Date of Birth ______________________________ ☐ *Male* ☐ *Female*

Home Address ______________________________

Parent/Guardian Name ______________________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Insurance Name ____________________ ID/Group Number ____________________

Insured ______________________________

ICD-10 Code(s) and description of code (Required) ______________________________

Past Surgery (please include dates) ______________________________

Goal for Motion Analysis: ☐ Orthopedic Surgical Planning ☐ Annual Video Program ☐ Other ____________________

Has the patient been seen in the Lab before? ☐ *Yes* ☐ *No*
Walks independently? ☐ *Yes* ☐ *No*
Uses orthoses? ☐ *Yes* ☐ *No* (*if yes, type?*____________________)
Uses walking aids? ☐ *Yes* ☐ *No* (*if yes, type?*____________________)

Please check all that are required:
☐ Standard Tests: (may include any combination of the following: Clinical Exam, Video, Motion, Kinetics)
☐ Surface EMG's: ☐ *Standard Protocol* ☐ *Other (please specify)*____________________
☐ Pedobarograph
☐ Fine wire EMG: ☐ *Posterior Tibialis* ☐ *Other (please specify muscles)* ____________________
Were patients notified? ☐ *Yes* ☐ *No*
☐ Upper extremity
☐ Video Only ☐ *Yes* ☐ *No* **If above tests are not covered by insurance**.
☐ Other ______________________________

Referring Physician Name ______________________________

Address ______________________________

Phone ______________________________

Signature ______________________________ ***Date*** ____________

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