Gait Laboratory
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St George's University Hospitals NHS
NHS Foundation Trust

GAIT ANALYSIS REFERRAL FORM

To the Referrer
Please complete sections 1 - 6 overleaf. Please ensure that the patient's GP completes the sections below before sending it to the Gait Laboratory.

To the GP
Please complete below with your details and sign to confirm that you are happy for us to proceed with the gait assessment for this patient. If you require any further information please contact us at the address above.

Patient Details	
Full Name (forename, surname):	Date of Birth:

GP Details	
Name:	
Address:	
Postcode:	
CCG:	
Signature of GP:	Date:

When completed, please return this form to the Gait Laboratory at the address above.

1. Patient Data	
Full Name (forename, surname):	Date of Birth:
Full Address: Postcode:	Gender: Male ☐ Female ☐ NHS Number:
Preferred Contact Telephone Number(s) *(if this is not the patient, please add a justification):*	Name and Relationship to Patient (if not patient):

*If referral is for a child, please also supply parent / guardian / carer name below**:***		
Full Name:	Relationship to Child:	Telephone Number:
Is the child known to social services? (if 'Yes', please add further details to section 6. Additional Information):		Yes ☐ No ☐

2. Details of Referrer	
Name of Referrer:	Date Form Completed:
Position:	
Address: Postcode:	
Telephone Number:	
Email Address:	

3. Reasons for Referral
Summarise the question(s) you hope to have answered/information you wish to obtain through the gait assessment.

Patient Name (forename, surname):	**Date of Birth:**

4. Clinical Data
Diagnosis:
Present gait problems:
Orthoses / walking aids used:
Current mobility *(include approximate distance and use of walking aids)*: **Patient can walk 10m barefoot ☐ if yes, describe walking aids needed:**

5. Type of Gait Assessment Requested	
Please place a mark in the box(es) as appropriate; for EMG indicate muscle(s) of interest.	
Video Analysis: ☐ Energy Consumption: ☐	
Video Vector: ☐	*Typically for comparison with orthoses*
Kinematic: ☐ EMG: ☐ Muscles of interest for EMG?	*Patient must be able to walk 10 m barefoot*

6. Additional Information	
Expected date of any planned interventions: *(for example: relevant surgery; orthotics or Botulinum Toxin injections)*	
Date by which you would like the gait assessment undertaken: *(Our aim is to see patients within 18 weeks of receipt of referral)*	
Date by which you would like the report completed: *(Our aim is to produce reports within 4 weeks of the appointment)*	
Please add any further information that you believe will be helpful for the assessment:	

This form MUST be completed by the referrer and the front sheet signed by the patient's GP

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