BROOKS Rehabilitation

Motion Analysis Center

Referral for Assessment
Adult/Pediatric/Adolescent

Phone (904) 345-8967
Fax (904) 345-8978

Patient Name	**Date of Birth**
Patient's Phone Numbers (home phone / cell phone)	**Insurance Type**
Diagnosis / ICD-9 code	**Onset of Current Condition**
Patient ID	**Surgical Procedure/Special Precautions**
Referring Healthcare Provider (Physician or Therapist)	**Location**

Type of Assessment:

☐ **Gait Analysis**

Reason for Consult:

☐ Pre/Post-Intervention Assessment

-Please specify post-assessment time frame:

_____

☐ Guide Treatment Selection

☐ Orthotic Assessment/Comparison

Type: _____

☐ Other (please describe)

_____

_____

_____

Mobility Status:

☐ Independent

☐ Assistance Required: _____

☐ Assisted Device Required: _____

Patient is able to walk 50 ft.: ☐Yes ☐ No

☐ **Sports Assessment**

Reason for Consult:

☐ Initial Assessment

-Please specify number weeks post-op:

_____

☐ Post Assessment (6-8 weeks after initial testing)

Specific Concerns:

_____

_____

_____

Patient is cleared for jumping tasks: ☐Yes ☐ No

Other/Comments:

I certify that I have examined the above patient and determined that a motion analysis assessment is necessary. I approve this treatment plan and will review it as necessary or as the patient's condition requires.

Physician's Signature: _____

Date:_____ Physician's Phone: _____

Physician's Fax (to send reports): _____

Physician's Location: _____

Physician's Office Stamp Here