MOTION ANALYSIS LAB REQUEST – SPORT EVALUATION
Prescription/Letter of Medical Necessity

Patient Name: _____ DOB: _____

VISIT TYPE

- ☐ **Running Analysis**
  - ☐ Long Distance Runner
  - ☐ Sprinter
  - ☐ Hamstring injury
- ☐ **ACL Return to Sport Analysis**
- ☐ **Throwing Analysis**
  - Do you want them throwing from a pitching mound? ☐Yes ☐No
- ☐ Other _____

TREATMENT ORDER

Required: ☐ Physical Therapy Evaluation (97161, 97162, 97163)

DIAGNOSIS: _____

INVOLVED LIMB (CHECK ONE)

Select one:

- ☐ LEFT LEG
- ☐ RIGHT LEG
- ☐ BILATERAL

PRECAUTIONS/CONTRAINDICATIONS: _____

The therapy service for the above named patient is medically necessary. A licensed therapist will treat my patient.

_____ _____ _____

Physician's signature **Printed Name** **Date**

_____

Contact Number/Email

*****Please fax orders & clinical information to 936-267-7904**

Texas Children's Hospital