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

Patient Name: _____ DOB: _____

DIAGNOSIS

- □ Cerebral Palsy
- □ Cerebral Vascular Accident
- □ Hereditary Spastic Paraparesis
- □ Idiopathic Toe Walking
- □ Spina Bifida
- □ Spinal Cord Injury
- □ Traumatic Brain Injury
- □ Other _____

QUALIFICATION CRITERIA

1) Able to walk under their own power for a minimum of 10 feet without stopping. The patient must be able to do this at least 10 times to complete the gait study.
   a. If needed, the patient may use any of the following assistive device(s): cane, crutches, standard anterior walker, or standard posterior walker. However, the gait study cannot be performed for patients who use a gait trainer or a walker with a hip belt (or pelvic support).
   b. For patients classified as GMFCS IV, please contact the Motion Analysis Lab at 936-267-6686 to determine whether the patient is appropriate for referral.
2) Able to follow verbal commands
3) At least five (5) years of chronologic age or greater, or behavior consistent with 5 year old

DOES PATIENT MEET THE ASSESSMENT QUALIFICATIONS (CIRCLE ONE)? YES NO

TREATMENT ORDER

Required:	□	Physical Therapy Evaluation (97161, 97162, 97163)
Select one:		
Standard:	□	Comp-Base Motion Analysis, VID/3-D Kinematics (96000)
Optional	□	Comp-Base Motion Analysis w/Dynamic Plantar Pressure Measurement (96001)
Select one or both:		
Standard:	□	Dynamic Surface EMG, Walking/Functional Activity, 1-12 Muscles (96002)
Optional:	□	Dynamic Fine Wire EMG, Walking/Functional Activity, 1-2 Muscles (96003)

EMG REQUESTED MUSCLES (CHECK ONE)

Select one:
- □ LEFT LEG
- □ RIGHT LEG
- □ BILATERAL

Select one:
- □ STANDARD SET (RECTUS FEMORIS, TIBIALIS ANTERIOR, SEMIMEMBRANOSUS, BICEPS FEMORIS, GASTROCNEMIUS)
- □ ADD ON: FINE WIRE POSTERIOR TIBIALIS (FOR VARUS FOOT)
- □ OTHER (PLEASE COMMENT)_____

TESTING CONDITIONS (CHECK ONE)

Select one or both:
- □ BAREFOOT
- □ ORTHOTICS (MAY ALTER EMG ASSESSMENT)

Select one:
- □ ASSISTIVE DEVICE (WITHOUT 3D KINETICS)
- □ WITHOUT ASSISTIVE DEVICE

REASON FOR REFERRAL (CHECK ONE) □ Pre-Surgical Planning □ Other_____ □ Post-Surgical

ANTICIPATED SURGERY DATE: _____

*NOTE: Please allow 6 weeks lead time to place Motion Analysis/Gait Study order

PRECAUTIONS/CONTRAINDICATION: _____

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 to 832-825-5209**

Texas Children's Hospital