External Referral Form for Gait Analysis Laboratory

Name:	
Address:	
DOB:	***Diagnosis:***

Referrer Information

Referring Clinician:	
Referrers Address:	
Date of Request for G.A:	
Physiotherapist:	
Medical Consultant:	

Can Client Walk Independent?	**Yes/No**	**If not, state habitual aids used:**
Can Client Follow Instructions?	**Yes/No**	
Reason for Referral/Gait concern:		
Relevant History:		
Treatment to date: **(Please state date and procedures carried out)**		
Any Relevant Investigations to date?		

Referring Clinician Signature: