Southern Adelaide Local Health Network
South Australian Movement Analysis Centre (SAMAC)
Paediatric Gait Analysis Referral

NOTE- For any queries regarding referrals
Please contact Ph: (08) 8404 2661
Email:Health.SAMACGaitlab@sa.gov.au

PATIENT DETAILS

Surname:	**DOB:**	**Phone:**
Given Name(s):	**Gender: M** ☐ **F** ☐	**Mobile:**
Address:	**Medicare no:**	**MRN:**
	GP Details Name:	Contact No:
Postal address (if different to above):	**Interpreter/Language: Yes** ☐ **No** ☐ If yes, details: ……	
Patient Consent to referral: Yes ☐ **No** ☐	**Aboriginal** ☐ **Both** ☐ **Torres Strait Islander** ☐ **Neither** ☐	

PARENT/GUARDIAN/PERSON RESPONSIBLE:

Name: **Relationship:** **Contact No:**

TYPE OF ANALYSIS REQUIRED:

Clinical Exam: ☐ **2DGA:** ☐ **3DGA:** ☐ **EMG:** ☐ Comment:

REASON FOR ANALYSIS:

Baseline: ☐ **Post-op: 6mths (2D)** ☐ **Post-op: 12mths (3D)** ☐ **Post-op: 24mths (3D)** ☐ **Other:** ☐ Comment:

WHEN REQUIRED:

Urgently: ☐ **3 mths:** ☐ **Waitlist:** ☐ Comment:

CLINICAL DETAILS:

Diagnosis:		**GMFCS:**	
FMS:		**Hip Status:**	
Walking Aids:		**Orthoses:**	
Able to walk 10x10m trials	**Yes** ☐ **No** ☐	**Assistance Required?**	**Yes** ☐ **No** ☐ Comment:

Other Details: (medical history, behavioural issues)

DESCRIPTION OF PRESENTING PROBLEMS:

PREVIOUS TREATMENT (including surgery and timing):

QUESTIONS TO BE ANSWERED BY GAIT ANALYSIS:

REFERRER'S DETAILS

Name:	**Designation**:	**Organisation:**
Signature:	**Phone/Pager:**	**Fax:**
Date of Referral:	**Email:**	

PLEASE FAX REFERRALS TO FAX: (08) 8404 2263

Government of South Australia
SA Health