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| **Patient’s Details:**  Surname....................................................  Forename(s)..............................................  Date of Birth..............................................  CHI number...............................................  Hospital Number........................................  Contact Address........................................  ...................................................................  ...................................................................  Contact Person..........................................  Telephone (Day)........................................  (Evening).......................................  Is consent given to leave messages on a landline? Y / N | **Referrer’s Details:**  Name.........................................................  Profession..................................................  Address......................................................  Telephone..................................................  Signature...........................Date.................  **Consultant’s Details (if not the same as above)**  Name.........................................................  Address......................................................  Telephone..................................................  Signature............................Date................ |

Gait Analysis Referral Form

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| **Requirements (Please Tick)**  Range of Movement...................................  Video..........................................................  Kinematic...................................................  Kinetic........................................................  EMG........................................................... | **Other Clinical Staff**  General Practitioner...................................  Medical Consultant....................................  Physiotherapist..........................................  Orthotist.....................................................  Other.......................................................... | |
| **Reason for Referral**  Please continue overleaf if necessary and attach other relevant documents | |
| **FOR OFFICE USE ONLY**  Date Received...........................................  Patient Number..........................................  Package Number....................................... | **PLEASE RETURN TO**  [Smart.Referrals@nhslothian.scot.nhs.uk](mailto:Smart.Referrals@nhslothian.scot.nhs.uk)  Or post to:  Anderson Gait Laboratory Manager,  Smart Services, Astley Ainslie Hospital,  133 Grange Loan, Edinburgh EH9 2HL  Tel: +44(0) 131 5379435 | |