Your patient ___________________________ is interested in participating in our 8-week Community Based Individualized Balance or Gait Retraining Program 2X/ week for 1 hour sessions. This program is designed to assist the person with a neurological disorder that is no longer eligible for traditional physical therapy services. The Gait Program may use Partial Body Weight Treadmill Training in which the person walks on a treadmill while wearing a harness for balance. This approach has been used with persons with spinal cord injury, stroke, as well as other neurological disorders. The person is monitored for adverse physiological changes including changes in blood pressure or heart rate. Please indicate below acceptable ranges for vitals during and after exercising for your patient listed above.

The Balance Program is for persons with significant balance disorders secondary to a neurological disorder, or who are falling, or are at high-risk for falling. The level of intensity of the program is based on the individual capabilities of each participant. The content of the balance program specifically addresses the balance-related impairments identified during the initial assessment. Participants engage in activities that are designed to improve their ability to control the center of gravity in dynamic balance environments, and restore balance quickly following an unexpected perturbation. Various exercises have been designed to progressively challenge the balance system. Exercises specifically designed to improve your patient’s ability to use the different sensory inputs for balance will also be included in the program.

If you know of any medical or other reasons why participation in either one of these programs by your patient would be unwise, please indicate so on this form. By completing the form below, you are not assuming any responsibility for the administration of the tests and/or balance or gait retraining program. If you would like a copy of the evaluation be sent to your office, please let us know.

If you have any questions about any aspect of the balance and gait retraining program, please call Dr. Peggy Trueblood, Professor Toni Tyner or Becky Cleary, Clinical Faculty in the Center at (559) 278-4148. They would be pleased to address any concerns and/or questions you may have about this community-based program conducted at CSU Fresno in the Department of Physical Therapy.

_____ I know of no reason why my patient should not participate in the proposed Gait or Balance Individualized Program.

_____ I believe my patient can participate, but I urge caution because __________________________________________________________________

_____ I recommend that my patient not participate in this program.

Physician Signature ___________________________ Date ________________
Print Name of Physician ___________________________ Phone # ________________

PLEASE FAX or MAIL COMPLETED FORM TO:
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Fresno, CA 93740-8031
FAX: (559) 278-3635