



**GAIT, BALANCE & MOBILITY  
RESEARCH, EDUCATION & TRAINING CENTER  
DEPARTMENT OF PHYSICAL THERAPY  
CALIFORNIA STATE UNIVERSITY, FRESNO**

Fall 20\_\_ Spring 20\_\_

\_\_\_\_\_  
PARTICIPANT

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:**

**Department of Physical Therapy  
California State University, Fresno  
2345 E. San Ramon Ave M/S MH29  
Fresno, CA 93740-8031  
FAX: (559) 278-3635**