



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

APPLICATION PACKET (8 weeks)

We will be offering our individualized gait and balance program again during the 2018 Fall Semester. This program is targeted for people with significant gait or balance problems due to a specific neurological disorder or for other individuals who have fallen or are at high-risk for falling who are no longer eligible for traditional physical therapy services. This program is conducted with doctoral physical therapy students enrolled in a course overseen by licensed clinical faculty. Please contact the PT department at 559-278-2625 to confirm placement and slot availability. For more information regarding this program, please see below.

PROGRAM: Community-Based Individualized Balance or Gait Retraining Program

DATES: **Tuesday, September 18 to Thursday, November 15 (8 weeks)***

Note: Clinic is held 2 times per week on Tuesdays and Thursdays.
Each session is 50 minutes.

***Please note that clinic will NOT be held on October 2 and October 30.** The dates have been adjusted accordingly in order to provide the full 8 weeks of therapy.

Classes are not held on official university holidays.

FEE: \$300 for 8-week session (not covered by private insurance or Medicare)

LOCATION: California State University Fresno, McLane Hall Room 111
(*Parking permits will be provided.*)

TO ENROLL FOR FALL 2018 SEMESTER:

1. Fill out the enclosed enrollment form. Please write clearly and complete all information.
2. Obtain a physician's clearance to participate in the program. (You may use the form attached). This clearance may be in any format and can be mailed with your packet or faxed to the Department of Physical Therapy (Attention: GBMC), FAX # 559-278-3635. You can submit your application without this, but please note that we must receive a signed clearance before you can participate in the program.
3. A deposit of \$100 is required to hold your requested time. Remaining balance of \$200 is due by the third week of the program. Make checks payable to **Fresno State** (cash or money orders are not accepted).
4. Send your deposit and completed enrollment form to:

Gait, Balance, and Mobility Center
Department of Physical Therapy
5315 Campus Drive, M/S PT29
Fresno, CA 93740-8031
5. We will try to accommodate any special circumstances for scheduling; however, we ask that you come in at the same time of day for each day of the class.

If you have any questions regarding this program, please feel free to contact Dr. Peggy Trueblood at 559-278-3008 or Dr. Leslie Zarrinkhameh at 559-278-4087.



Gait, Balance, and Mobility Center Department of Physical Therapy California State University, Fresno

Enrollment Form

Fall 20__ Spring 20__

Please write clearly and complete all information.

Date: _____

Name: _____ Birth Date _____

Address: _____

City/ State/ Zip Code: _____

Phone Number: _____

Email: _____

Emergency Contact Person: _____

Diagnosis: _____

Physician (Name and Address): _____

Chief Complaint: _____

Past Medical History: _____

Medications: _____

Have you fallen in the last year? _____

If so, how many times? _____

Primary Goal(s) for the Program _____

Preferred Class Time: (Circle those you can attend)

AM 9:00 10:00 11:00

PM 2:00 3:00 4:00

I **DO** or **DO NOT** have a DMV Handicap Parking Pass. (Please Circle one)

Please send this form and your deposit (\$100 check payable to Fresno State) to:

Gait, Balance and Mobility Center
Department of Physical Therapy
5315 N. Campus Drive, M/S PT 29
Fresno, CA 93740- 8031
(559) 278-2625



Gait, Balance, and Mobility 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 and Department Chair (559-278-3008) or Professor Leslie Zarrinkhameh (559-284-4087). They would be pleased to address any concerns and/or questions you may have about this community-based program conducted at Fresno State 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 EMAIL FORM TO:
 Department of Physical Therapy
 California State University, Fresno
 5315 N. Campus Drive, M/S 29
 Fresno, CA 93740-8019
 FAX: (559) 278-3635