Diabetic and Comfort Shoes
A way to the sole

PRESCRIPTION FOR DIABETIC FOOTWEAR, DIABETIC INSERTS
&
Statement of Certifying Physician for Therapeutic Shoes

Start Date of Order_____

Patient Information:

Name: _____ D.O.B:_____M____ F____
Address: _____
HIC# _____Phone:_____

Estimated Length of Need(# of months):_____ 1-99(99=Lifetime
Prognosis: _____good _____fair _____poor

DIAGNOSIS CODES _____ _____
CODES (ICD-9):

(Please check or initial the prescription below)

_____ I prescribe 2 pr off the shelf depth shoes and 3 pr multi-density inserts or custom foot orthotics.

Additional Instructions: _____

By signing below I certify that all of the following statements are true:

1) This patient has diabetes mellitus
2) This patient has one or more of the following conditions **(Circle all that apply)**
   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity (bunions, hammertoes, pedal edema, pes planus/cavus, calcaneal vulgus/varus, charcoat foot, etc)
   f) Poor circulation
3) I am treating this patient under a comprehensive plan of care for his/her diabetes. This patient needs special shoes (depth or custom-molded shoes) and inserts because of his/her diabetes.
4) I have seen and evaluated patient's feet within the last 6 months. Date of visit: ___/___/___.

Physician's Signature: _____ **Date Signed**: _____
Physician's Name (printed, **must be M.D. or D.O.**) _____
Address: _____
Phone: _____ NPI#_____

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