Statement of Certifying Physician for Therapeutic Shoes

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIB#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that all the following statements are true:

1. This patient has diabetes mellitus – ICD10 code *(E11. \_\_\_\_\_\_)*
2. This patient has one or more of the following conditions *(circle all that apply)*:
	1. History of partial or complete amputation of the foot
	2. History of previous foot ulceration
	3. History of pre-ulcerative callus
	4. Peripheral neuropathy with evidence of callus formation
	5. Foot deformity
	6. Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special (depth or custom molded) shoes and/or inserts because of his/her diabetes.

DIABETIC FOOTWEAR PRESCRIPTION

 (Please Check Selection)

Extra Depth Diabetic Shoes (A5500) 1 PAIR Custom Molded Diabetic Shoes (A5501) 1 Pair

|  |  |
| --- | --- |
|  |  |
|  Toe Filler (L5000)  Right Left Partial Foot (L5020) Right Left  |  |
|  |  |
| Physician Signature: | MD or DO Date: |
|  |  |

Custom Diabetic Foot Orthosis (A5514/A5513) 3 Pair Heat molded prefab Diabetic Inserts (A5512)

 3 PAIR

 Physician Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician Address:

Physician NPI: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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