Smith's Drugs of Forest City

Home Medical Equipment
139 East Main Street
Forest City, NC 28043
(828) 245-4591 Fax: (828) 245-1793

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____ Date of Birth: _____

Patient Address: _____ HIC Number: _____

Please answer the following statements regarding your patient's condition:

1) This patient has diabetes mellitus.
   ❑ Yes ❑ No

2) This patient has one or more of the following conditions:
   a) History of partial or complete amputation of the foot……....❑ Yes ❑ No
   b) History of previous foot ulceration…….❑ Yes ❑ No
   c) History of pre-ulcerative callus……..❑ Yes ❑ No
   d) Peripheral neuropathy with evidence of callus formation……..❑ Yes ❑ No
   e) Foot deformity……❑ Yes ❑ No
   f) Poor circulation……...❑ Yes ❑ No

3) I am treating this patient under a comprehensive plan of care for his/her diabetes.
   ❑ Yes ❑ No

4) This patient needs special shoes (depth or custom-molded) because of his/her diabetes.
   ❑ Yes ❑ No

I certify that I have answered the preceding statements truthfully:

Physician Signature: _____ Date: _____

Physician Name (printed – MUST BE A M.D. or D.O.): _____

Physician Address: _____

Physician Phone: _____ NPI: _____