

**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: \_\_\_\_\_