Smith's Drugs of Forest City

Home Medical Equipment

139 East Main Street

Forest City, NC 28043

Phone: (828) 245-9215 Fax: (828) 641-9677 or (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: ________________________