## Prescription for Therapeutic Footwear
## (MD, DO, DPM, NP, PA, CNP)

Patient Name: _____ Chart #: _____

DOB: _____ Today's Date: _____

Check all that apply:

- ☐ Diabetes Mellitus: ICD-10: ____
- ☐ Hammertoe(s)
- ☐ Bunion(s)
- ☐ Ulcer(s)
- ☐ Callus(es)
- ☐ Amputation(s)
- ☐ Charcot Deformity
- ☐ Plantar Fascitis
- ☐ Edema
- ☐ Neuroma
- ☐ Corn(s)
- ☐ Ankle Instability
- ☐ Drop Foot
- ☐ Posterior Tib. Disorder
- ☐ Peripheral Vascular Disease
- ☐ Neuropathy
- ☐ Other: _____

The patient requires:

☐ Diabetic Footwear, non custom (A5500) – 1 pair (unless otherwise indicated)

With:

☐ Custom molded inserts (A5513) – 3 pairs (unless otherwise indicated)

Lesions requiring offloading: L 1 2 3 4 5
R 1 2 3 4 5

☐ Non custom, heat moldable inserts (A5512) – 3 pairs (unless otherwise indicated)

☐ Toe Filler (L5000)

Comments: _____

_____

_____

Clinician Name: _____

Signature: _____ Date: _____

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## Diabetic Verification Form
## (MD or DO Only)

Patient Name: _____ DOB: _____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus. ICD-10 Code: _____

2) This patient has one of the following conditions:
(check all that may apply)

- ☐ History of partial or complete amputation of the foot
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ History of previous foot ulceration
- ☐ Foot deformity
- ☐ History of pre-ulcerative callus
- ☐ Poor circulation

3) Within the past 6 months, an exam has been performed and qualifying condition(s) have been documented.

4) I am treating this patient under a comprehensive plan and care for his/her diabetes.

5) This patient needs special shoes (depth or custom-molded) and/or inserts because of his/her diabetic condition.

**Certifying Physician Information:** **(must be signed by a MD or DO)**

**Signature:** _____ **Date:** _____

**Name:** _____

**Address:** _____

**NPI #:** _____

**Signature:** _____ **Date:** _____

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