CDS #10 PHARMACY
Fast Service - Expert Healthcare
1308 Ashley Circle, Bowling Green, KY 42104
www.cds10.com
Ph: (270) 781-5661
Fax: (270) 781-5652

Patient's Name _____ Date of Birth _____

Patient's Address _____

Men's ☐ Women's ☐ Size: _____ #Inserts: _____

********** PLEASE ANSWER ALL QUESTIONS TO VALIDATE FORM **********

**********Please circle the diagnoses that apply**********

Please state from the patient's medical record, the nature of the foot disorder that warrants the need for shoes. This patient has one or more of the following conditions:

		Circle one or more
A.	Corns & Callosities	700
B.	Great toe angles toward other toes	735.0
C.	Traumatic amputation of toe without complication	895.0
D.	Bone Spur	726.91
E.	Other acquired deformities of the tow (i.e., hammer toe, bunion(s), etc.)	735.8
F.	Open wound of toe(s) without complications	893.0
G.	Great toe angles away from other toe(s)	735.1
H.	Open wound of toe(s) with complications	V49.72
I.	Diabetes with peripheral circulatory disorders	250.70

		Circle Y/N
1.	This patient has Diabetes Mellitus. Please list ICD 10: _____	Y or N
2.	This patient needs 1 pair of extra-depth inlay therapeutic shoes And 3 pairs of multi-density heat moldable inserts.	Y or N
3.	I am treating this patient under a comprehensive plan of care for his/her diabetes	Y or N

By signing below, I state that the patient named above has diabetes and is being treated by me under a comprehensive plan of care for the patient's diabetes. All the information contained in this statement is true and correct to the best of my knowledge.

Physician Name: _____ Ph/Fx: _____

Physician Address: _____

Physician Signature: _____

This form stands as a CMN, Doctor's Orders, and Statement of Certifying Physician

Certified Fitter Signature: _____

Certified Fitter has been approved by the American Board for Certification in Orthotics, Prosthetics & Pedorthics, Inc. and has more than 1,000 hours experience.

Faxed on: _____

PLEASE INCLUDE PATIENT CHART NOTES*