REQUIRED DOCUMENTATION FROM PHYSICIAN

(TO GET DIABETIC SHOES)

Detailed Written Order (Form Attached)

*Must have multiple ICD10 codes on Diagnosis Line on form.

Prescription for Therapeutic Footwear/Statement of Certifying Physician (Form Attached)

*Must have multiple diagnosis under **Check all that apply:** section of Prescription for Therapeutic Footwear form.

Foot Exam Form (Form Attached)

Regular prescription for shoes

Chart notes indicating need of diabetic footwear

Ken Glover Drug

Office Number 205 648 9918

Fax Number 205 648 9644

Detailed Written Order

Patient:________________________________ DOB____________________

Start Date if other than date signed:__________ Length of Need___Lifetime__

Diagnosis ICD 10 Code____

____

*Must have multiple Diagnosis codes for diabetic footwear

Procedure Code_____________A5500_____A5512__________________________

____

Items to be Dispensed___Diabetic Shoes__________________________________

______________________3 Pair Non Custom Heat Moldable Inserts_______

____

____

____

____

Physician's Signature__________________________________Date____________

Physician's Printed Name______________________________NPI_____________

Prescription for Therapeutic Footwear

(MD, DO, DPM, NP, PA, CNP)

Patient Name: ____________________ Chart #: ___________

D.O.B.: _____________ Today's Date: ______________

Check all that apply:

- ☐ Diabetes Mellitus
- ☐ Hammertoe(s)
- ☐ Bunion(s)
- ☐ Ulcer (s)
- ☐ Callus (es)
- ☐ Amputation(s)
- ☐ Charcot Deformity
- ☐ Fascitiis
- ☐ Edema
- ☐ Neuroma
- ☐ Corn (s)
- ☐ Ankle instability
- ☐ Drop foot
- ☐ Posterior Tib. Disorder
- ☐ Peripheral Vascular Disease
- ☐ Neuropathy

The patient requires:

- ○ Diabetic Footwear, non custom (A5500)- 1 pair (unless otherwise indicated)

With:

- ○ Non custom, heat moldable inserts (A5512)-3 pairs (unless otherwise indicated)
- ○ Custom molded inserts (A5513)-3 pairs (unless otherwise indicated)

  Lesions requiring offloading: L 1 2 3 4 5

  R 1 2 3 4 5
- ○ Toe filler (L5000)

  Comments: ____

  ____

  ____

Clinician Name: ______________________________________

Signature: ________________________ Date: _________

PLEASE FAX TO KEN GLOVER DRUG
205 648 9644

Statement of Certifying Physician

(MD or DO only)

Patient Name: ___________________________ D.O.B. ____________

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD- 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. I am treating this patient under a comprehensive plan and care for his/her diabetes.
4. 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: ____

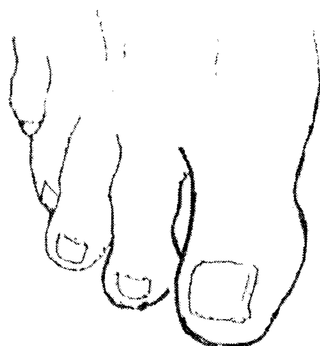
Address: ____

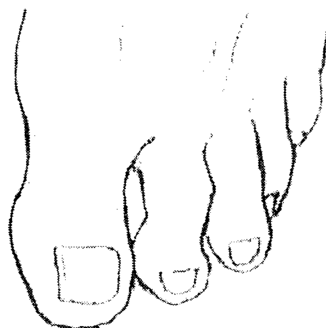
DEA#: _____________ **Medicare UPIN:** ______________

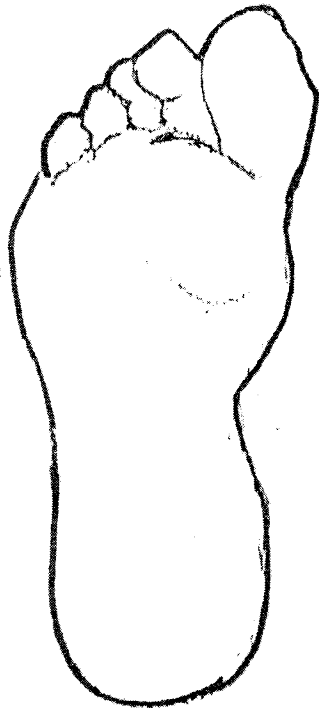
Enrolled in PECOS: ☐ Yes ☐ No

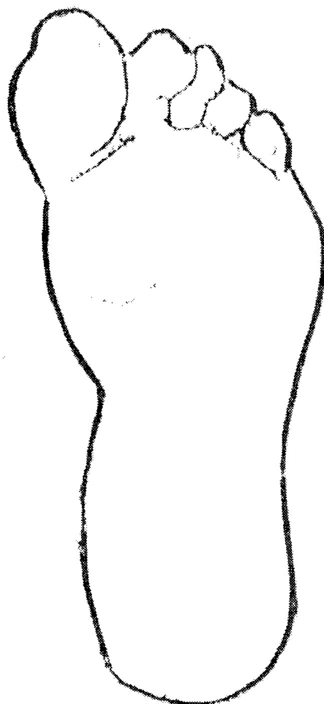
ANNUAL DIABETES FOOT EXAM FORM

Note placement of
- calluses,
- pre-ulceration areas,
- ulceration areas, or
- areas lacking sensitivity.









Comments:

Right foot

Comments:

Left foot

NAME:

DOB:

MR#:

Circle or check findings as they apply

Hx of amputation?	Right / Left	
Hx of ulceration?		
Right:	No Yes	Date:__________
Left:	No Yes	Date:__________
Pt able to see bottom of feet?	No	Yes
Pt wearing properly fitting shoes?	No	Yes

FOOT EXAM

☐ **Foot exam WNL**

☐ **PAD exam WNL**

(If abnormal-circle which foot)

Foot ulcer?	No /	Right /	Left
Abnormal shape?	No /	Right /	Left
Charcot foot?	No /	Right /	Left
Toe deformity?	No /	Right /	Left
Thick or ingrown toenails?	No /	Right /	Left
Callus build-up?	No /	Right /	Left
Edema?	No /	Right /	Left
Elevated skin temp?	No /	Right /	Left
Decreased circulation?	No /	Right /	Left
Loss of sensation?	No /	Right /	Left
Muscle weakness?	No /	Right /	Left

PERIPHERAL ARTERY DISEASE (PAD) SCREEN

History of claudication?	No	Yes
Pedal pulses present?	No	Yes

Notes:

Ankle Brachial Index (ABI) obtained? No Yes

Results:

NOTES:

REFERRAL MADE TO:

To:

Appt Date:

Exam Date:

Signature: