

Diabetic Shoes & Inserts Rx Order Form

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Phone number: _____

RX:

- 1 Pair Diabetic Shoes (R&L)
- 3 Pairs of Inserts (R&L)

Foot Measurements

1. Heel to Toe

Right Foot	Left Foot	Comments

Men Widths

Woman Widths

M= Medium

N= Narrow

W= Wide

M= Medium

XW= Extra Wide

W= Wide

XW= Extra Wide

Shoe Choice (Choose 2 Models in case your 1st choice is unavailable)

	Model Name	Color	Size	Width
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Ordering Physician: _____