Patient Name ____________ Date of Birth ____________

HIC # ____________ Phone # ____________

Diabetic Shoes & Inserts

Shoe Type: ☐ Lace ☐ Velcro ☐ Male ☐ Female

☐ Lycra ☐ Leather MFG: StrideLite Size: ______

Insert Type: ☐ *Custom Molded from Model of Patient's Foot* ☐ *Heat Moldable*

Statement of Certifying Physician for Therapeutic Shoes & Inserts

I certify that all of the following statements are true:

1. The patient has diabetes mellitus (Please check one from each column)
   - ☐ Uncontrolled ☐ Non Insulin Dependent
   - ☐ Controlled ☐ Insulin Dependent
2. The patient has one or more of the following conditions: (please check)
   - ☐ History of partial or complete amputation of foot
   - ☐ History of previous foot ulceration
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ History of pre-ulcerative callus
   - ☐ Foot Deformity
   - ☐ Poor Circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. Therapeutic Shoes (Extra Depth) and Inserts are a medical necessity because of his/her diabetic condition.

Physician Name ____________

Phone Number ____________ Fax Number ____________

Address ____________

Physician's NPI # ____________ Medicaid # ____________

Physician's Signature ____________ Date ____________

Prescription for Therapeutic Shoes

Patient Name ____________

HIC # ____________ Date of Birth ____________

Dx: *Diabetes Mellitus*

Other Dx:

Rx:

- ☐ *Extra Depth Therapeutic Shoes*
- ☐ *Custom Molded Diabetic Inserts*
- ☐ *Heat Moldable Diabetic Inserts*

Other Rx:

Physician Name ____________

Phone Number ____________ Fax Number ____________

Address ____________

Physician's NPI # ____________ Medicaid # ____________

Physician's Signature ____________ Date ____________