

Statement of Certifying Patient for Therapeutic Footwear

Patient Name: _____ HIC #: _____

Address: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus. ICD-9 Code: _____
(ICD-9 diagnosis codes 250.00-250.93)
2. This patient has one or more of the following conditions (check all that apply):
 - History of partial or complete amputation of the foot
 - Peripheral neuropathy with evidence of callus formation
 - History of previous foot ulceration
 - 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. This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.

Certifying Physician Information

Signature: _____ Date: _____

Name: _____ DEA#: _____

Medicare UPI#: _____ Medicaid Provider#: _____

Prescription Form for Therapeutic Footwear

(Prescribing physician may be different from certifying physician.)

Patient Name: _____ HIC #: _____

Address: _____

Diagnosis: _____

Change to be effected: _____

Additional relevant information, such as systemic conditions or allergies to specific materials:

Prescribing Physician Information

Signature: _____ Date: _____

Name: _____ DEA#: _____

Medicare UPI#: _____ Medicaid Provider#: _____

Adapted from *Feet Can Last a Lifetime: A Healthcare Provider's Guide to Preventing Diabetic Foot Problems* from the National Diabetes Education Program/National Institutes of Health (www.ndep.nih.gov/index.htm).

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