TERRY'S SHOES

FOOT CARE CENTER

DIABETIC CERTIFICATION AND PRESCRIPTION

PATIENT NAME:____DATE:____________________________

ADDRESS:____

CITY:____STATE:__________________ZIP:_________________________

PHONE: (______)____DATE OF BIRTH:_________/_________/________

HIC#____

"I certify that all of the following are true."

1. The patient has diabetes mellitus **ICD-10 CODE:____**
2. The patient has at least one of the following: **(CIRCLE ALL THAT APPLY BELOW)**
   A. **Poor circulation of either foot.**
   B. **Foot deformity of either foot (bunions, hammer toes, ect.)**
   C. **Peripheral neuropathy with callus formation on either foot.**
   D. **History of pre-ulcerative callus.**
   E. **History of previous foot ulcerations.**
   F. **Previous amputation of part of either foot.**
3. I am treating this patient under a comprehensive plan of care for his or her diabetes.
4. Therapeutic shoe's (extra depth shoes) with diabetic inlays is part of a comprehensive plan in treating this patient.

PRESCRIPTION:

_______ Extra depth shoes with 3 pairs of molded inserts or modification; or custom molded footwear.

Modifications or other instructions:

____

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I authorize the items/services herein and certify that the devices are medically necessary for this patient and that the information provided herein is true, accurate, and documented in the patient's clinical notes.

Prescribing Physician (signature):____

Print Name:____NPI#________________________Date:_____/____/_____

Address:____

City:____State:_______Zip:_____________Phone:________________________

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