Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

Patient Telephone :_____Patient Date of Birth:_____

HIC #:_____

I certify that all of the following are true:

1. This is a patient with diabetes mellitus — ICD-9 Code:_____

(ICD-9 diagnosis codes 250.00-250.91)

2. This patient has one or more of the following conditions: (check all that apply)

- o History of partial or complete amputation of the foot
- o History of previous foot ulceration
- o History of pre-ulcerative callus
- o Peripheral neuropathy with evidence of callus formation
- o Foot deformity
- o Poor circulation

3. I am treating this patient under a comprehensive plan of care for his or 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:_____

Physician Name (Print):_____

Physician address:_____

_____

Physician UPIN #:_____

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