Footwear Consultants, Inc.

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC FOOTWEAR

Patient Name: _____ Phone #: _____

Address: _____ Date of Birth: _____

Medicare #: _____ Secondary Insurance: _____

1. This patient has diabetes mellitus: (please check one)

   _____250.00 Type II Controlled _____250.01 Type I Controlled

   _____250.02 Type II Uncontrolled _____250.03 Type I Uncontrolled

2. I am treating this patient under a comprehensive plan of care for Diabetes.

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

   _____A. History of partial or complete amputation of foot.

   _____B. History of previous foot ulceration.

   _____C. History of pre-ulcerative callus.

   _____D. Peripheral neuropathy with evidence of callus formation.

   _____E. Foot deformity.

   _____F. Poor circulation.

4. This patient needs special footwear (depth or custom molded footwear) and/or inserts because of their diabetic condition.

5. Any additional work to be done, such as shoe build up, toe filler, etc. _____
   _____

DX: _____
(ICD-9 Diagnosis codes)

Physician signature:_____

Physician name (printed):_____

Physician address:_____

Physician phone #: _____ **Physician UPIN:** _____ **NPI:**_____

Physician Fax #: _____ **Date Signed:** _____

Doctor, Please <u>fill out completely</u> and keep a copy of this referral in your patient's file.

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Raymond Strasburg – Board Certified Pedorthist