HOSFORD SHOES & ORTHOPEDIC LAB PH(865) 688-9495 FAX (865) 688-1188 3403 N. Broadway, Knoxville,TN 37917

Statement of Certifying Physician for Therapeutic Shoes

Patient: _____

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 – 250.91)
2. This patient has one or more of the following conditions.
(Circle all that apply.)

DESCRIPTION

a.) History of partial or complete amputation of the 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

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.

Physician signature: _____

Date Signed: _____
Physician Name (printed): _____
Physician address: _____
Physician UPIN: _____

Physician Prescription Form

Patient's Name _____Date _____

Address _____

City _____ State _____ZIP _____

Phone(__)_____Age ____ Patient's Medicare ID#_____

DX:
___Previous Amputation
___Previous Ulceration
___Pre-ulcerative Callus
___Peripheral Neuropathy w/Callus Formation
___Foot Deformity
___Poor Circulation

RX:
___Custom-Molded Shoes
___Depth Shoes
___Customized/Custom Orthosis
___Roller-Bottom Sole or Bar
___Rigid Rocker-Bottom Sole or Bar
___Sole/Heel Wedge (Circle One)
___Metatarsal Bar
___Offset Heel
___Other

ORTHOSIS: ___LEFT ___RIGHT _____ B/L
SHOE MODIFICATION: ___LEFT SHOE ___RIGHT SHOE

INSTRUCTIONS: _____

_____

_____

PRESCRIBING PHYSICIAN INFORMATION:

Signature _____

DEA # _____

Medicare UPIN # _____

Medicaid Provider # _____

Please note: For Medicare filing, foot examination chart notes must accompany this form prior to evaluation and fitting by C.Ped.