

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

PATIENT NAME: _____

HIC# _____

I certify that all of the following statements are true:

- 1) The patient has diabetes mellitus, ICD-9 code: _____
- 2) This patient has one or more of the following conditions:
 - History of partial or complete amputation of the foot
 - Peripheral neuropathy with evidence of callus formation
 - History of previous foot ulceration
 - Foot deformity
 - History of pre-ulcerative callus
 - Poor circulation
- 3) I am treating this patient under a comprehensive plan of care for his/her diabetes.
- 4) This patient needs special shoes and or inserts because of his/her diabetes.

Physician Signature: _____ Date _____

Physician name (please print): _____

Address: _____

UPIN# _____