FOOT HEALTH CENTER

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STATEMENT OF CERTIFYING PHYSICIAN FOR THERPEUTIC SHOES

Patient Name: Last First M.I.

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 (please check all that apply):

- ☐ 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
- ☐ At risk for breakdown
- ☐ Other

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 Name (please print) UPIN#

Street Address City State Zip

Physician Signature Date