Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

Patient Date of Birth: _____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus

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

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

d) Foot deformity

f) Poor circulation

3) I am treating this patient under a comprehensive plan for his/her diabetes

4) This patient needs special shoes (depth or custom-molded shoes), and inserts not to exceed three pairs per year, for his/her diabetes

Physician Signature (MUST BE M.D. OR D.O.): _____

Date Signed: _____

Physician Name (printed): _____

Physician Address: _____

Physician NPI#: _____