STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

PATIENT NAME: _____

HIC (MEDICARE) #:_____

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 (Check all that apply):

- History of partial or complete amputation of the foot
- History of previous foot ulceration
- History of pre-ulcerative callous
- Peripheral Neuropathy with evidence of callous formation
- Foot deformity
- 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):_____
(Must be an M.D. or D.O.)

Address: _____

_____

UPIN#_____

NOTE TO PATIENTS: Medicare requires that your primary care physician (doctor treating your diabetes) complete this form. Once signed, please call 543-7788 (San Luis) or 434-2009 (Templeton) to schedule an appointment with Travis Freitas, Certified Pedorthist to be evaluated for diabetic shoes and/or insoles.