

Statement of Certifying Physician for Therapeutic Shoes

Patient name: _____

HIC #: _____

I certify that all of the following statements are true:

- 1) This patient has diabetes mellitus.
- 2)
- 3) This patient has one or more of the following conditions. (Circle all that apply):
 - 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
- 4) I am treating this patient under a comprehensive plan of care for his/her diabetes.
- 5)
- 6) This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature:

Date Signed: _____

Physician name (printed – must be M.D. or D.O.):

Physician address:

Physician UPIN:
