

# 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) 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
- 3) I am treating this patient under a comprehensive plan of care for his/her diabetes.
- 4) 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:** \_\_\_\_\_

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**Physician UPIN:** \_\_\_\_\_