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:**_____

Physician Name (*PRINTED—MUST BE M.D. OR D.O.***):**_____

Physician Address:_____

_____

_____

Physician NPI:_____

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