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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 the 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): _____

Physician address: _____

Physician NPI: _____ Phone #: _____

Please fax back to our office at (732) 349-6549