ORDER FORM

DIABETIC SHOES

Patient's Name_____ MALE◯ FEMALE◉ DOB_____

Medicaid#_____ Medicare#_____ Phone#_____

Address_____ City_____ Zip_____

ITEMS PRESCRIBED

☐ Diabetic Shoes Size _____
☐ Shoe Inserts ☐ Other_____

DIAGNOSIS

1. _____

2. _____

I certify that all of the following are true:

1. 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 callus
   - ☐ Peripheral neuropathy with evidence of callus formation
   - ☐ Foot deformity
   - ☐ Poor circulation
2. I am treating this patient under a comprehensive plan of care for his or her diabetes
3. This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of diabetes

Physician's name_____ NPI# _____

Address_____ Phone#_____

Physician's Signature _____ Date _____

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Referred by:_____