



STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPUTIC SHOES

Patient Name : _____

HIC #: _____

I certify that all 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 an M.D. Or D.O.)

Physician NPI: _____

Physician address:

