Physical Rehabilitation Services, LLC

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Therapeutic Shoes for Persons with Diabetes Statement of Certifying Physician Template

Patient Information:

Last name: _____ First name: _____ MI: ____

DOB (MM/DD/YYYY):_____ Gender: __ M __ F __ Other Medicare ID:_____

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 (check all that apply)

_____History of partial or complete amputation of the foot

_____History of previous foot ulceration

★ _____History of pre-ulcerative calli

_____Peripheral neuropathy with evidence of callus formation

_____Foot deformity

_____Poor circulation

3. I am treating this patient under a comprehensive plan for his/her diabetes.

4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Signature, name, date, and NPI (must be an M.D. or D.O.)

★ Signature: _____

Name (Printed): _____

Address:_____

_____

City:_____ State:_____ Zip:_____

★ Date (MM/DD/YYYY): _____ NPI:_____