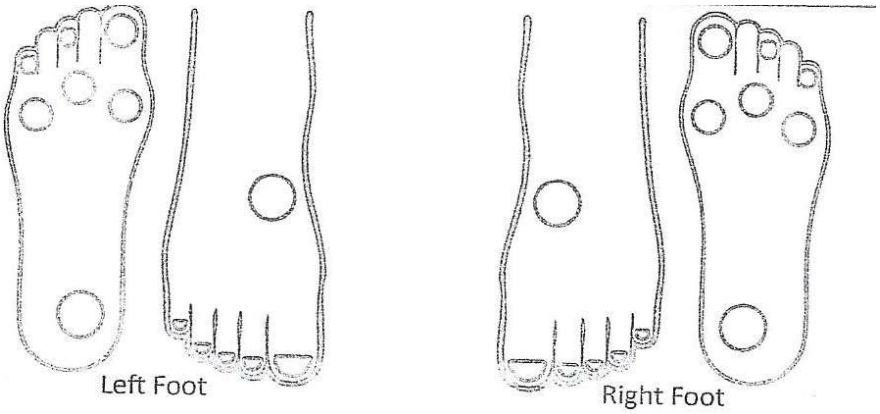
Patient's Name: _____ Phone: _____ Date of Birth: ____/ ____/ _____
Address: _____ City: _____ State: _____ Zip: _____
Medicare #: _____ Other Insurance: _____ ☐ Male ☐ Female

Chart Documentation: Show areas of callus formation, swelling of feet, and any other areas of concern with abbreviated condition on the foot chart below.

Foot Condition & Codes:
Callus Formation……C
Deformity……...D
Ulcers……..U
Peripheral Neuropathy……PN
Hammer Toes…….H
History of Ulcers……HU
Swelling……..S
Bunions……..B
Redness……..R
Amputation……...A
Pre-Ulcerative Callus Formation…..PUCF



Notes:
_____
_____

Color: _____ ☐ Lace ☐ Velcro® Current Size: _____ Width: _____

Prescription: Footwear, In-Depth (1 Pair) with ☐ Custom ☐ Heat Molded Orthotics (3 Pair)
Statement of Certifying Physician for Therapeutic Shoes.

Please Answer Questions 1 thru 5- Check all that Apply

1.) Verification: Chart notes must be available for foot condition & Diabetes when ordering this product.
2.) This patient has Diabetes Mellitus ☐ Yes ☐ No - ICD.10 Code for Diabetes __ __ __ . __
3.) This patient has one or more of the following conditions (please check all that apply)
- ☐ Poor Circulation - ICD.10 Code __ __ __ .__
- ☐ Peripheral Neuropathy with evidence of callus formation – ICD.10 Code __ __ __ . __
- ☐ Foot Deformity (bunions, hammertoes, etc.)- ☐ Right Foot ☐ Left Foot
- ☐ History of foot ulcerations- ☐ Right Foot ☐ Left Foot
- ☐ History of partial or complete amputation of the foot – ☐ Right Foot ☐ Left Foot
- ☐ History of pre- ulcerative callus – ☐ Right Foot ☐ Left Foot

4.) I am treating this patient under a comprehensive plan of car for his/her Diabetes – ☐ Yes ☐ No
5.) This patient needs special depth shoes because of his/her Diabetes – ☐ Yes ☐ No

Please Note:

This section along with number 1-5 must be filled out completely in order for prescription to be covered by insurance.

I CERTIFY THAT ALL OF THE PRECEDING STATEMENTS ARE TRUE & THAT DOCUMENTATION OF SUCH IS IN PATIENT'S CHART

Physician's (treating the Diabetes) Signature (M.D. or D.O.): _____ **Date:** _____
Physician's Name (printed): _____ _____ ☐ MD ☐ DO NPI#: _____
Physician's Address: _____ City: _____ State: _____ Zip: _____
Physician's Phone: _____ Fax: _____

Please See Your Physician to Have This Form Completed. Return to One Source Medical Solutions for Your Custom Fitting.

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Dallas, Texas 75235

Phone: (214) 421-7000 Fax: (214) 421-7001
Toll Free: (877) 4RX SHOES

Member of the American Board for Certification in Orthotic, Prosthetics, & Pedorthics
Member of the American Diabetes Association
Member of the Pedorthic Footwear Association