<u>Statement of Certifying Physician for Therapeutic Shoes</u>

Patient Name**:** ____

MBI: ______________________________

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 that apply and must document in progress note**):

a) History of partial or complete amputation of the foot (**When and where on foot**)

b) History of previous foot ulceration (**When and where on foot**)

c) History of pre-ulcerative callus (**When and where on foot**)

d) Peripheral neuropathy **with** evidence of callus formation (**Both must be documented**)

e) Foot deformity (**Specify deformity on foot**)

f) Poor circulation at site of foot (**ie. Abnormal Capillary refill test, pedal pulses, ultrasound**)

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 address: ________________________

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Physician NPI: ______________________________