

PRESCRIPTION/Detailed Written Order

For Diabetic Shoes and Inserts



Village Discount Drugs

The Problem Solvers & People Pleasers

Patient Name: _____ DOB: _____

ADDRESS: _____ DATE: _____

Per **Statement of the Certifying Physician**, the patient has one or more of the following foot conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Previous Amputation | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Previous Ulceration |
| <input type="checkbox"/> Foot Deformity | <input type="checkbox"/> Pre Ulcerative Callus | <input type="checkbox"/> Poor Circulation |

Type of Shoe Prescribed: Extra-Depth (A5500) Custom Molded (A5501)

Number of Shoes: 2

Type of Inserts Prescribed: Heat-Moldable (A5512) Custom Fabricated (A5513)

Number of insoles: 6

Additional Instructions or Modifications: _____

Prescribing Physician's Signature

Date Signed

Prescribing Physician's Name (Printed)

NPI

Diabetic Foot Exam Form

Patient: _____

Type I Diabetes _____ Type II Diabetes _____

Neurological:

Vibratory or PIN Sensation: (R) _____
Normal Diminished Absent (L) Normal
Diminished Absent

Vascular:

Dorsalis Pedis: (R) absent weak normal
(L) absent weak normal
Posterior Tibial: (R) absent weak normal
(L) absent weak normal
Cap.Fill: (R) instant 1 sec 2 sec 3 sec
(L) instant 1 sec 2 sec 3 sec

Dermatologic:

Hair: (R) _____ (L) _____
Skin color: (R) _____ (L) _____
Skin Temp:(R) _____ (L) _____
Plantar Keratosis (callus):
(R) 1 2 3 4 5 MPJ Other _____
(L) 1 2 3 4 5 MPJ Other _____
Digital Keratosis (corns):
(R) 1 2 3 4 5 (L) 1 2 3 4 5
Edema: (R) Pitting _____ Brawny _____
(L) Pitting _____ Brawny _____
Ulcer: (R) _____
(L) _____

Foot Deformity:

(R) Bunion, Hammertoes, Bunionette
(L) Bunion, Hammertoes, Bunionette
Other: (R) _____
(L) _____
Amputation, foot: Full or Partial (R) _____
(L) _____

Foot assessment:

This patient qualifies for extra depth therapeutic footwear and

_____ Custom fabricated full contact inserts
(A5513), or
_____ Medicare compliant heat molded full
contact inserts (A5512)

These shoes and inserts are medically necessary to achieve and maintain contact with the plantar aspect of the patient's foot, and to help prevent irritation and tissue breakdown.

I am also sending a certification statement so the extra depth shoes and inserts can be ordered and dispensed for my patient.

Signature, M.D. _____ D.O. _____
Date _____

MUST BE SIGNED BY PHYSICIAN ONLY

This examination is part of the medical record

_____ Date _____

Signature, M.D. _____ D.O. _____