ADVANCED CARE FOOT & ANKLE

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Statement of Certifying Physician for Therapeutic Shoes

Patient name: ______________________________

HIC #: ______________________________

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 the 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): ______________________________

Physician address: ______________________________

Physician NPI: ____________________ Phone #: ____________________

Please fax back to our office at (843) 604-0566