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:

___ Previous Amputation ___ Peripheral Neuropathy ___ Previous Ulceration

___ Foot Deformity ___ Pre Ulcerative Callus ___ 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)

Amputation, foot: Full or Partial (R)_____
(L)_____

_____ Date_____

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

_____
(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