

## Statement of Certifying Physician For Therapeutic Shoes

Patient Name \_\_\_\_\_

HIC # \_\_\_\_\_

MHN \_\_\_\_\_

### CIRCLE ALL THAT APPLY:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions.  
(Circle all that apply):
  - a) History of partial or complete amputation of 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.

I certify that all of the preceding circled statements are true.

Physician Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Physician name (printed-MUST BE A M.D. OR D.O.): \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician UPIN: \_\_\_\_\_