2620 Mineral Springs Ave, Suite A
Knoxville, TN , 37917
Phone: 865-247-4809
Fax: 865-247-4927

Prescription for Diabetic Shoes

Date:_____________
Patient Name:____
Patient DOB:_______________Patient Phone:____________________

1) Type of Shoes prescribed (check):
   ☐ Extra Depth (A5500)- I pair, unless otherwise noted
   ☐ Custom Molded (A5501) - Nature and severity of deformity must be documented in physician's notes for eligibility.

2) Type of inserts prescribed (check one)
   ☐ Heat Moldable (A5512)- 3 Pairs
   ☐ Custom Fabricated (A5513)- 3 Pairs

ICD Notes and Special Instructions:____
____
____

DX CODES:____

Physician Signature:______________________________
Physician Name:_________________________________
Physician NPI:__________________________________
Physician Phone:________________________________
Physician Fax:__________________________________
Physician Address:______________________________

Please make sure forms are filled out completely and signed by an M.D. or D.O.
Forms can not be signed by a P.A. or N.P.
Until we receive completed documentation we can not see the patient in our office.
Please be sure to attach clinical notes when returned.

Statement of Certifying Physicians

Date:_____________
Patient Name:____
Patient DOB:_______________Patient Phone:____________________

☐ Yes ☐ No This Patient has diabetes mellitus

☐ Yes ☐ No Qualifying Conditions: I have diagnosed that this patient has one or more of the following conditions: (Check all that apply)
   ☐ History of partial or Complete amputation of the foot
   ☐ History of previous foot ulceration
   ☐ History of pre-ulcerative callus
   ☐ Peripheral neuropathy with evidence of callus formation
   ☐ Foot deformity
   ☐ Poor Circulation

These conditions must be clearly stated in clinical notes

☐ Yes ☐ No I am treating this patient under a comprehensive plan for care of his/her diabetes.

☐ Yes ☐ No This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

☐ Yes ☐ No This patient needs shoe inserts (heat molded or custom fabricated) because of his/her diabetes.

Physicians Signature:____________________________________
Physician Name:__________________________________
Physician NPI:___________________________________
Physician Phone:_________________________________
Physician Fax:____________________________________
Physician Address:_________________________________