TWIN CITIES ORTHOPEDICS

Statement of Certifying Physician for Therapeutic Shoes/Foot Orthoses

This form must be completed by the M.D. or D.O. managing the patient's diabetic condition.

Patient's Name: _____ DOB: _____

1. **This patient's feet were last examined by me on:** _____

2. **I certify that ALL the following are true ***MUST CHOOSE ALL 3*****

- ☐ This patient has diabetes mellitus.
- ☐ I am treating this patient under a comprehensive plan of care for his/her diabetes.
- ☐ This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

3. **QUALIFYING CONDITIONS: (check all that apply)**

I have diagnosed this patient and have included my notes showing that he/she has one or more of the following conditions:

- ☐ History of partial or complete amputation of the foot
- ☐ History of previous foot ulceration
- ☐ History of pre-ulcerative foot callus
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Foot deformity – specify: _____
- ☐ Poor circulation
- ☐ This patient has none of the above conditions

Physician's Signature: _____

Must be an M.D. or D.O.

Physician's Printed Name: _____

NPI#: _____ Date: _____

Physician's Phone: _____

Physician's Address: _____

_____

PLEASE BE SURE TO INCLUDE THE CLINICAL NOTES FROM YOUR LAST DIABETIC EVALUATION APPOINTMENT AND FAX BACK TO 952-456-7038