Statement of Certifying Physician for Therapeutic Footwear

Patient Name: _____

Address: _____

Phone: _____

I certify that all of the following are true:

1. This patient has diabetes mellitus ICD-10 Code:_____
2. This patient has one or more of the following conditions *(Check all that apply):*

- ❑ History of partial or complete amputation of the foot
- ❑ Peripheral neuropathy with evidence of **callus formation**
- ❑ History of previous foot ulceration
- ❑ Foot deformity (Bunion, Hammertoe, etc.)
- ❑ History of pre-ulcerative callus
- ❑ 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) and inserts.
5. Patient is taking the following medication (s):

_____

_____

Certifying Physician Information

Doctor Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____

NPI #_____

**This form should be filled out by the physician managing the patient's diabetes, and faxed to Personal Podiatry Associates or the patient can bring it to their appointment.*

Personal Podiatry Associates, PA

954-721-3411

954-721-3772 Fax

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PERSONAL PODIATRY ASSOCIATES

✔ Personal Podiatry Associates must receive this statement from the physician actively treating you for diabetes. Please have it filled out and bring it to your appointment with Personal Podiatry Associates.

✔ We will always use the highest standards of quality and workmanship.

✔ We will always take the necessary time to measure your foot with the Brannock device to ensure a precise shoe fit.

✔ Unlike most of our competitors, we take a direct contact impression of your foot, guaranteeing the mold will be your exact fit. No digital which could lead us to a larger margin of error than direct contact impressions.

"Quality care with a personal touch!