Mt. Sterling Healthy Foot Center
570 Indian Mound Drive
Mt. Sterling, KY 40353
(859) 498-3141

Prescription for Therapeutic Shoes and Inserts

PLEASE FAX TO: 859-498-2434

Patient Name:_____ **HICN:**_____
Date Of Birth:_____ **Patient Phone #:**_____
Prescriber Name:_____ **Prescriber Phone #:**_____

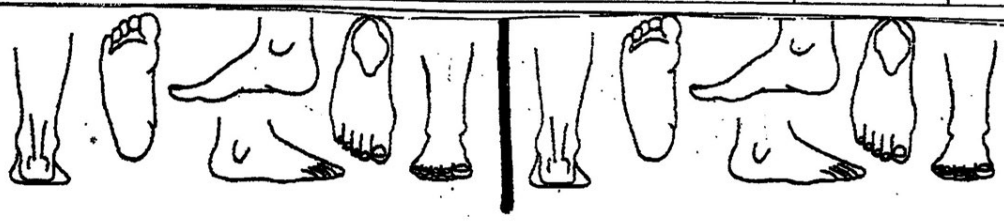
Quantity (Please check)	**HCPC Code**	**Description**
1 [ ]	A5500	Diabetic Depth Shoes, pair
3 [ ]	A5512	Prefabricated inserts pairs—multiple density
	OR	
3 [ ]	A5513	Custom-molded inserts—Multiple density, molded to model of patient's foot.

Primary Diagnosis Code: ____ ____ ____.____ ____

Please confirm that the entered Diagnosis Codes match your charting documentation.
(Example: E11.9, E10.9, E11.65, E11.40, E10.40, E11.51, E10.51). Duration of usage: 12 months

Physical Exam:

Neurological (Use Y or N)	**Right**	**Left**	**Vascular (Circle Appropriate level)**	**Right**	**Left**
Loss of Vibration Perception			Dorsalis Pedis (3=Normal)	0 1 2 3 4	0 1 2 3 4
Loss of Protective Sensation			Posterior Tibial (3=Normal)	0 1 2 3 4	0 1 2 3 4



RIGHT FOOT **LEFT FOOT**

Note any calluses, bunions, swelling, redness, deformities, or amputations using the symbol key below:
C-Callus B-Bunion S-Swelling R-Redness D-Deformity HC-Hammer/Claw Toe A-Amputation W-Wound

Prescriber Signature:_____ **Date:**_____

Prescriber Name (Printed):_____ Prescriber NPI#: _____
Must be the MD, Do or other eligible prescriber who is actively treating patient's diabetes (e.g. PA, Licensed Nurse Practitioner, Clinical Nurse Specialist, DPM)
Note: Shoes must be dispensed within 6 months from when diabetes care was discussed by Certifying Physician with patient.

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____ DOB: _____

MBI: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.

2. This patient has one or more of the following conditions. **(CIRCLE ALL THAT APPLY)**
   a) History of previous foot ulceration
   b) History of pre-ulcerative callus
   c) Peripheral neuropathy with evidence of callus formation
   d) Foot deformity
   e) 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.

Physician signature: _____

Date Signed: _____

Physician name (printed-**MUST BE AN M.D. OR D.O.**):

_____

Physician Address: _____

_____

_____

Physician NPI: _____