Albemarle
ORTHOTICS & PROSTHETICS

Required Documentation to Qualify for Diabetic Shoes

1. **Signed detailed prescription**
   **Signed/cosigned and dated by MD or DO only*

2. **Diabetic verification form**
   **Signed/cosigned and dated by MD or DO only*
   **Form must be completed within last three months*

3. **Office visit notes**
   **Notes must pertain to diabetic exam and include medication list, A1C lab results, foot exam form, and diabetic treatment notes*
   **Signed/cosigned and dated by MD or DO only*
   **All office visit notes must be within last six months*

4. **Comprehensive foot exam form**
   **Signed/cosigned and dated by MD or DO only*

Please note: Paperwork signed by any other provider will not be accepted by Medicare. It must be cosigned by MD or DO and dates to qualify patient for diabetic shoes.

Thank you for choosing
Albemarle Orthotics & Prosthetics

Albemarle ORTHOTICS & PROSTHETICS

Thank you for choosing
Albemarle Orthotics & Prosthetics

Please send all necessary paperwork to one of our convenient locations:

Elizabeth City Office
106 Medical Drive
Elizabeth City, NC 27909
Phone: 252-338-3002
Fax: 252-338-2902/6461

Suffolk VA Office
148 Burnett's Way, Suite 104
Suffolk, VA 23434
Phone: 757-934-2676
Fax: 757-934-2751

Washington NC Office
405 W. 15th Street
Washington, NC 27889
Phone: 252-940-1203
Fax: 252-940-1206

Ahoskie NC Office
103 NC Hwy 42 West
Ahoskie, NC 27910
Phone: 252-332-4334
Fax: 252-332-4611

Greenville NC Office
1970 A West. Arlington Blvd.
Greenville, NC 27834
Phone: 252-378-9770
Fax: 252-378-9880

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

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 partial or complete amputation of the 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.

Physician signature: _____

Date Signed:_____

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

_____

Physician address:

_____

_____

_____

Physician NPI: _____

revised June 2007

Comprehensive Diabetes Foot Examination Form

Adapted from the National Diabetes Education Program's Foot Screening Form

Name: **Date:** **Age:**

Age at Onset: **Diabetes Type** ☐ 1 ☐ 2 **Current Treatment:** ☐ Diet ☐ Oral ☐ Insulin

I. Medical History
(Check all that apply.)
☐ Peripheral Neuropathy
☐ Cardiovascular Disease
☐ Nephropathy
☐ Retinopathy
☐ Peripheral Vascular Disease

A1C:_____

A1C Date:_____

II. Current History
1. Any change in the foot or feet since the last evaluation?
☐ Yes ☐ No
2. Current ulcer or history of a foot ulcer?
☐ Yes ☐ No
3. Is there pain in the calf muscles when walking that is relieved by rest?
☐ Yes ☐ No

III. Foot Exam
1. Are the nails thick, too long, ingrown or infected with fungal disease?
☐ Yes ☐ No

2. Note foot deformities.
☐ Toe deformities ☐ Bunions ☐ Charcot foot ☐ Foot drop
☐ Prominent metatarsal heads
☐ Amputation (Specify date, side and level.)
_____

3. Pedal Pulses
(Fill in the blanks with a "P" or an "A" to indicate present or absent.)

Posterior tibial:	Dorsalis pedis:
Left	Left
Right	Right

4. Skin Condition (Measure, draw in and label the patient's skin condition using the key and foot diagram to the right.)

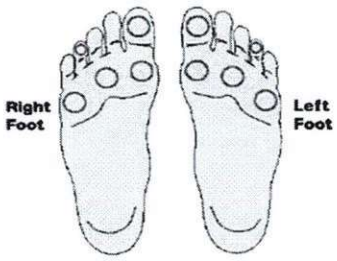
C = Callus R = Redness W = Warmth

F = Fissure S = Swelling U = Ulcer

M = Maceration PU = Pre-ulcerative lesion D = Dryness

IV. Sensory Foot Exam
Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 Semmes-Weinstein (10-gram) nylon filament and "-" if the patient cannot feel the filament.

NOTES *NOTES*



V. Risk Categorization (Check appropriate item.)

Low-Risk Patient
All of the following:
☐ Intact protective sensation ☐ No severe deformity
☐ No prior foot ulcer ☐ Pedal pulses present
☐ No severe deformity ☐ No amputation

High-Risk Patient
One or more of the following:
☐ Loss of protective sensation
☐ Absent pedal pulses
☐ Severe foot deformity
☐ History of foot ulcer

VI. Footwear Assessment
1. Does the patient wear appropriate shoes?
☐ Yes ☐ No
2. Does the patient need inserts/orthotics?
☐ Yes ☐ No

VII. Education
1. Has the patient had prior foot care education?
☐ Yes ☐ No
2. Can the patient demonstrate appropriate self-care?
☐ Yes ☐ No

VII. Management Plan (Check all that apply.)
☐ Provide patient education for preventive foot care. ☐ Refer to an APMA member podiatrist or an appropriate physician.

Date:_____ Provider Signature:_____