

Instructions

- 1) Take this form to your podiatrist or prescribing physicians
- 2) Take the same form to your diabetic physician for certification of your diabetic condition
- 3) Bring this form completed by your doctors to A.M. Comfort Shoes or call 773-925-4184

PRESCRIPTION FOR DIABETIC SHOES		FOOT DOCTOR		
PATIENT NAME _____				
Date	D.O.B.	HIC #		
_____	_____	_____		
_____ Amputation of toes	895.00	Physician Name	_____	
_____ Amputation of Foot	896.00		Address	_____
_____ Previous Ulceration	707.10		City	_____
_____ Pre-Ulcer Callus	250.80		State/Zip	_____
_____ Peripheral Neuropathy Non-Insuli	250.60		Tel	_____
_____ Peripheral Neuropathy Insulin	250.60		Fax	_____
_____ Foot Deformity	735.00		NPI #	_____
_____ P.V.D.	443.90			
_____	Extra Depth Shoes			
_____	Custom Molded Shoes			
_____	Dual Density Inserts			
Addt _____		Signature	_____	

STATEMENT OF CERTIFYING PHYSICIAN		MEDICAL DOCTOR		
PATIENT NAME _____				
Date	D.O.B.	HIC#		
_____	_____	_____		
<i>I certify that all of the following statements are true:</i>				
_____ This patient has diabetes mellitus		Physician Name	_____	
_____ History of partial or complete amputation of the foot			Address	_____
_____ History of previous foot ulceration			City	_____
_____ Peripheral neuropathy with evidence of callus formation			State/Zip	_____
_____ Foot deformity			Tel	_____
_____ Poor circulation			Fax	_____
		NPI	_____	
_____ I am treating this patient under a comprehensive plan of				
care his/her diabetes		Signature	_____	
_____ This patient needs special shoes (Depth or Custom				
Molded Shoes) because of his/her diabetes				