Dietitians At Home
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Patient was Referred by:

PHYSICIAN'S ORDER - THERAPEUTIC DIABETIC SHOES

Patient Name		**Patient Phone Number**
Patient Address		**Patient DOB**
City	**State**	**Zip**
Effective Date	**Patient Insurance Number**	

ORDER FOR: A5500 (2) DIABETIC DEPTH INLAY SHOES & A5512 (6) HEAT MOLDABLE DIABETIC INSERTS

Patient has diabetes mellitus. – Check all that apply

- ☐ E10.65 Type 1 DM w/ Hyperglycemia
- ☐ E10.9 Type 1 DM w/o Complications
- ☐ E10.8 Type 1 DM w/ Complications
- ☐ E10._____Type 1 DM Other
- ☐ E11.65 Type 2 DM w/ Hyperglycemia
- ☐ E11.9 Type 2 DM w/o Complications
- ☐ E11.8 Type 2 DM w/ Complications
- ☐ E11._____ Type 2 DM Other

I certify that all of the following statements are true - Check all that apply

☐ The patient has one or more of the following conditions:

- ☐ History of partial or complete amputation of the foot
- ☐ Peripheral neuropathy with evidence of callus formation
- ☐ Poor circulation
- ☐ History of previous foot ulceration
- ☐ Foot Deformity
- ☐ History of Pre-ulcerative Callus

☐ I am treating this patient under a comprehensive plan of care of their diabetes.
☐ The patient needs special shoes (depth shoes) because of his/her diabetes.

Order must be signed by an MD or DO only.
I have examined this patient within the last 6 months. **DATE LAST SEEN: ____/____/_____**

I the undersigned, certify that the above prescribed equipment is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

Physician Signature			**Date**
Physician Name			**Physician NPI**
Physician Address			**Physician Phone**
City	**State**	**Zip**	**Physician Fax**