Medical Equipment

2718 W. 15TH. Ave Emporia, Ks. 66801
PH: 620-343-1800 FAX: 620-343-1859

Diabetic Shoe Order Form

Date: ____________________ ☐ M ☐ F

Name: ________________________________ DOB: ________________

Address: ______________________________ City: ________________

State: _____________ Zip: ____________ Telephone: ________________

Diagnosis: _____________________ Length of Need: ___________________

☐ A5500 **One pair of therapeutic off-the-shelf depth-inlay shoes, manufactured to accommodate multi-density insert(s).** One pair per year

☐ A5512 **Three pair of multi-density inserts for the therapeutic shoes.** 3 pairs per year

Statement of Certifying Physician

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.

Verbal Order: ☐Y ☐ N

Order Completed by: ______________________________ Date: ______________

Physician Signature: ______________________________ Date: ______________

Physician Printed Name: ______________________________ **NPI:** ______________

Address & Phone Number: ____

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