

# PRESCRIPTION FORM

## Therapeutic Shoes for Persons with Diabetes and Complications (TSD)

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Dx	Rx
<p><b>1. Diagnosis:</b> _____</p> <p><b>2. Secondary diagnosis, complication to Diabetes:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Lower limb amputation, foot (V49.73 &amp; 755.38)</li><li><input type="checkbox"/> Lower limb amputation, great toe (V49.71 &amp; 755.39)</li><li><input type="checkbox"/> Lower limb amputation, lesser toe(s) (V49.72 &amp; 755.39)</li><li><input type="checkbox"/> Ulcer of heel and midfoot (707.14)</li><li><input type="checkbox"/> Ulcer other part of foot (707.15)</li><li><input type="checkbox"/> History of pre-ulcerative callus (707.9)</li><li><input type="checkbox"/> Polyneuropathy in diabetes (357.2) <u>and</u> History of pre-ulcerative callus (707.9) <b>BOTH MUST BE DOCUMENTED</b></li><li><input type="checkbox"/> Claw toe (735.5)</li><li><input type="checkbox"/> Hammer toe (735.4) Other _____</li><li><input type="checkbox"/> Hallux valgus (735.0)</li><li><input type="checkbox"/> Hallux rigidus (735.2)</li><li><input type="checkbox"/> Unspecified acquired deformity of toe (735.9)</li><li><input type="checkbox"/> Unspecified deformity of ankle and foot, acquired (736.70)</li><li><input type="checkbox"/> Charcot Arthropathy (713.5)</li><li><input type="checkbox"/> Atherosclerosis of the extremities, unspecified (440.20)</li><li><input type="checkbox"/> Atherosclerosis of the extremities with intermittent claudication (440.21)</li><li><input type="checkbox"/> Atherosclerosis of the extremities with ulceration (440.23) Peripheral vascular disease, unspecified (443.9)</li><li><input type="checkbox"/> Other (Specify): _____ _____</li></ul> <p><b>3. Enclose detail substantiating the complication to diabetes</b> (tests exams, inspections, findings, etc. that were used to come to the conclusion that the condition exists)</p>	<p><b>4. Prescription</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Depth Shoes (A5500)<ul style="list-style-type: none"><li><input type="checkbox"/> Custom Molded Inserts (A5513)</li><li><input type="checkbox"/> Prefabricated, Heat Molded Inserts (A5512)</li></ul></li><li><input type="checkbox"/> Custom Molded Shoes (A5501) &amp; Custom Molded Inserts (A5513)</li><li><input type="checkbox"/> Custom Toe Filler (L5000) (Left Right) Qty of units per foot (circle one) : 3 2 1</li></ul> <p><b>Modifications (may not be a covered benefit)</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Rigid Rocker Bottom Sole/Bar (A5503)</li><li><input type="checkbox"/> Sole/Heel Wedge) (A5504)</li><li><input type="checkbox"/> Metatarsal Bar (A5505)</li><li><input type="checkbox"/> Other Modifications (Medial Stabilizers, Lateral Stabilizers, etc.) (A5507) _____ _____ _____</li></ul>

**Please fax Rx to (270) 747-8779**

**PRESCRIBING PHYSICIAN INFORMATION:**

Physician Name (printed) \_\_\_\_\_

Physician Address \_\_\_\_\_  
\_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician NPI # \_\_\_\_\_

Physician Phone # \_\_\_\_\_

**PATIENTS: PLEASE CALL AHEAD FOR AN APPOINTMENT 617-787-8779**

**Boston Pedorthic. 1929 Commonwealth Avenue, Brighton MA 02135. Tel 617-787-8779. Fax 270-747-8779**

## Statement of Certifying Physician (SCP) for Therapeutic Shoes

*This document must be signed by the M.D. or D.O. managing the patient's systemic diabetic condition*

Patient Name: \_\_\_\_\_ Patient Telephone: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

I certify that all of the following are true:

1. This is a patient with diabetes mellitus **ICD-9 Code:** \_\_\_\_\_ (ICD-9 diagnosis codes 249.00-250.93)

2. This patient has one or more of the following conditions: (**check all that apply**)

- History of partial or complete amputation of the foot
- History of previous foot ulceration
- History of pre-ulcerative callus
- Peripheral neuropathy with evidence of callus formation
- Foot deformity
- Poor circulation

3. Detail about the above conditions is contained in attached clinical notes that I have prepared or that another clinician as prepared and I have reviewed, and signed and dated **upon the document**, indicating my agreement. **<PLEASE FAX OR MAIL>**

4. I have seen this patient within the last six months, as shown in a copy of notes of their visit. **<PLEASE FAX OR MAIL>**

5. I am treating this patient under a comprehensive plan of care for his or her diabetes.

6. This patient needs special shoes (depth or custom-molded shoes) and/or inserts because of his/her diabetes.

Certifying Physician Information

\_\_\_\_\_  
Physician Name (Printed) MD or DO (circle one) \_\_\_\_\_ 2011  
Physician Signature \_\_\_\_\_ Date

\_\_\_\_\_  
Physician Address \_\_\_\_\_ Physician NPI # \_\_\_\_\_

\_\_\_\_\_  
Physician Phone # \_\_\_\_\_

Questions: Call (617) 787-8779 • Fax (270) 747-8779 info@bostonpedorthic.com

Reservoir Towers, 1929 Commonwealth Avenue, Brighton, MA 02135

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**Please fax or mail this completed form to  
Boston Pedorthic or to your patient**