Prescription

THERAPEUTIC FOOTWEAR FOR
PERSONS WITH DIABETES & FOOT COMPLICATIONS

Patient Name _____

Patient DOB_____ Patient Telephone _____

Dx _____

Rx

☐ *One pair* ☐_____ *pairs*

☐ *Depth Shoes*

☐ *Custom Molded Shoes*

☐ *Three pairs* ☐_____ *pairs*

☐ *Custom Foot Orthotics**

_____

☐ *Non-Custom Foot Orthotics**

_____

** Please specify reason for foot orthotics, or this prescription may not be valid for some payors*

Other Items

B/L L R _____

B/L L R _____

B/L L R _____

Prescriber Signature _____ Date_____

Prescriber Name (Printed) _____

Prescriber NPI _____

Telephone _____ Fax_____

To expedite, include recent progress notes.

Boston Pedorthic

Fax to 270-747-8779

Tel 617-787-8779