Hagen Orthotics & Prosthetics, Inc.

STATEMENT OF CERTIFYING PHYSICIAN FOR THERAPEUTIC SHOES

Patient Name (please print): _____DOB:_____

HIC #:_____

Please complete the following:

1. This patient has diabetes mellitus - ICD-9 Code:_____
   (ICD-9 diagnosis codes 250.00-250.93)

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. 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) and/or inserts because of his/her diabetes.

Physician signature: _____

Date Signed: _____

Physician name (printed): _____ UPIN: _____
(**Must be an M.D. or D.O.**)

Physician address: _____ Phone:_____

_____ Fax:_____

_____

Please Fax the completed form to 320-222-3262