Atlantic Foot & Ankle Specialists

PODIATRIC & SPORTS MEDICINE · FOOT & ANKLE SURGERY · WOUND CARE

Melissa Robitaille, DPM · Todd Newsom, DPM · Christin Runkel, DPM · Brian Fallon, DPM
Kristian Jeffress DPM · Julie Ferland DPM · Demon Thompson, CPED

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

HIC #: _____

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.
5. I have had an in-person visit with the patient during which diabetes management was addressed within the last 6 months.

   Date of visit: _____

Physician signature: _____

Date Signed: _____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

_____

Physician address:

_____

_____

_____

Physician NPI: _____

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