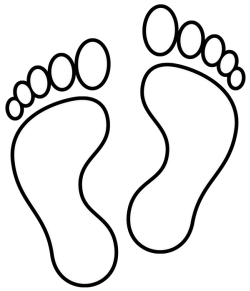
Shoe Qualification Form

Diabetic Exam



Note deformities on the images using the symbol key below:
A:Amputation B:Bunions
C:Callus H:Hammer Toes
P:Plantar Flexed Met
R:Redness S:Swelling
W:Wound/Ulcer

Vascular

Dorsalis Pedis
Posterior Tibial
Capillary Refill
Swelling

	Left		Right	
	[]Normal	[]Diminished	[]Normal	[]Diminished
	[]Normal	[]Diminished	[]Normal	[]Diminished
	[]<3 sec	[]>3 sec	[]<3 sec	[]>3 sec
	[]yes	[]no	[]yes	[]no

Neurological

Protective Sensation(LOPS)

Left		Right	
[]Normal	[]Diminished	[]Normal	[]Diminished

Dermatological

	Left	Right
Corn/Callus	[]	[]
Redness	[]	[]
Wound/Ulcer	[]	[]
Hair Growth Absent	[]	[]
Skin Texture	[]	[]

Musculoskeletal

	Left	Right
Amputation	[]	[]
Bunions	[]	[]
Hammer Toes	[]	[]
Prominent Met(s)	[]	[]

Temp Assessment

Left			Right		
[]Normal	[]Inc	[]Dec	[]Normal	[]Inc	[]Dec

_____ Date:_____

Signature DPM:

_____ Date:_____

Signature (M.D. or D.O. ONLY, No Stamps):

Certifying Physician Acknowledgement: I am the MD/DO supervising this patients diabetes care. As required by Medicare for eligibility for therapeutic shoes. I will keep a copy of this exam as part of my medical records.

DIABETIC SHOE CLINIC

1(888)470-5593 (859)545-4989

Patient Name:_____ DOB:_____

I Certify that all the following statements are true

1: This Patient has diabetes mellitus
[ICD-10 Code: E10.4,E11.4,Z79.4,Z79.84]

2: This Patient has one of the following conditions
(Mark all that apply)

[] History of partial or complete amputation of the foot
[] Peripheral neuropathy w/evidence of callus formation
[] History of previous foot ulceration
[] Foot Deformity
[] History of pre-ulcerative callus
[]Poor circulation

3: Within the past 3 months an exam has been preformed and qualifying condition(s) have been documented

4:I am treating this patient under a comprehensive plan and care for his/her diabetes. DATE LAST SEEN:_____
[PROVIDE NOTES REGARDING PLAN]

5:This patient needs special shoes (depth or custom-molded) and/or inserts because of their diabetic condition
[] I have reviewed, concur, initialed and dated Podiatry Foot Exam
[] I have preformed a diabetic foot exam

(M.D. or D.O. ONLY, No Stamps)

Signature: _____ Date:_____

Physician Name:_____

Address:_____

NPI:_____