DIABETIC FOOT EXAM FOR THERAPEUTIC SHOES

Person to contact if questions: ______________________ Date of Evaluation: __________

Patient Name: __________________________________ HICN #: ________________

1 Diabetes Type:

☐ Type I, Controlled **(1)** ☐ Type II, Controlled **(0)** ☐ Type I, Uncontrolled **(3)** ☐ Type II, Uncontrolled **(2)**

2 Diabetes Management (Required to support discussion of diabetes management)

Plan of Care: ☐ Diet ☐ Oral Meds ☐ Injection ☐ Pump

Treatment Plan:

Start Date: ____________ Duration of DM: __________ Date of Last FBS: ____________

3 Physical Exam:

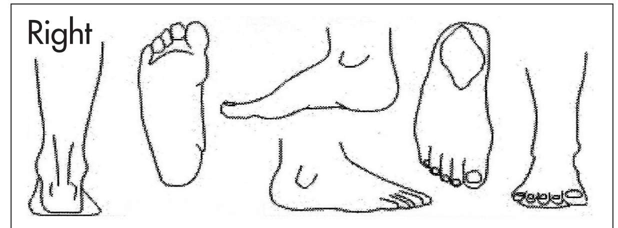
Neurological (use Y or N)	**Right**	**Left**
Loss of Vibration Perception		
Loss of Protective Sensation		

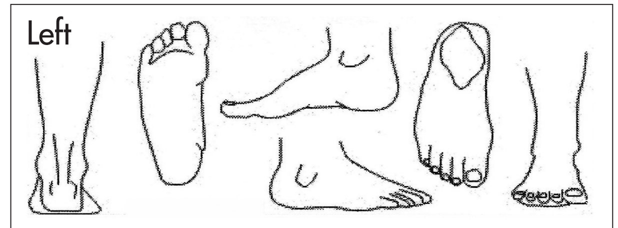
Vascular (circle appropriate level)	**Right**	**Left**
Dorsalis Pedis (3 = normal)	0 1 2 3 4	0 1 2 3 4
Posterior Tibial (3 = normal)	0 1 2 3 4	0 1 2 3 4

4 Physical Exam Part 2: Please refer to the findings when noting secondary risk factor(s) on "Statement of Certifying Physician"

Please Indicate any calluses, bunions, swelling, redness, deformities, amputation or wounds using the symbol key below:

Callus **C** Bunion **B** Swelling **S** Redness **R**
Deformity **D** Hammer/Claw Toe **HC**
Amputation **A** Wound **W**





5 Diagnosis Code: ___ ___ ___ ___ ___

6 Certifying Physician Acknowledgment*

I am the MD/DO supervising the patient under a comprehensive plan of care for Diabetes Mellitus. I have personally conducted this foot examination or have authorized an eligible prescriber to conduct this exam on my behalf and agree with the findings. I have incorporated this exam as part of my medical records. Part of the comprehensive plan of care for this patient includes therapeutic shoes and insoles.

Physician Signature: ______________________________ Date: ________________
(Stamped signature not allowable)

Physician Name: ______________________________ Physician NPI #: ____________
(printed)

***Please complete ALL steps as indicated.**
As required by Medicare, save in patient's chart.